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Compliance	**Q1.** Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits for consumers that are beginning to take effect or that will become effective very soon. What is the Departments' basic approach to implementation?	**A1.** The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Grandfathered Health Plans	**Q2.** After the interim final regulations on grandfathered health plans were issued, some issuers commented that they do not always have the information needed to know whether (or when) an	**A2.** The Departments have determined that, until the issuance of final regulations, they will not treat an insured group health plan that is a grandfathered plan as having ceased to be a grandfathered health plan immediately based on a change in the employer contribution rate if the employer plan sponsor and issuer take the following steps: Upon renewal, an issuer requires a plan	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	employer plan sponsor changes its rate of contribution towards the cost of group health plan coverage. (Generally, the interim final regulations provide that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate based on cost of coverage towards the cost of coverage by more than 5 percentage points below the contribution rate on March 23, 2010.) For purposes of determining whether an insured group health plan is a grandfathered health plan, what steps should issuers and employer plan sponsors take to communicate regarding changes to	sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year. For policies renewed prior to January 1, 2011, issuers should take these steps no later than January 1, 2011. If these steps are taken, an insured group health plan that is a grandfathered health plan will continue to be considered a grandfathered health plan. The relief in this Q&A2 will no longer apply as of the earlier of the first date on which the issuer knows that there has been at least a 5-percentage-point reduction or the first date on which the plan no longer qualifies for grandfathered status without regard to the 5-percentage-point reduction. Moreover, nothing in the Affordable Care Act or the interim final regulations prevents a policy, certificate, or contract of insurance from requiring a plan sponsor to notify an issuer in advance (e.g., 30 or 60 days in advance) of a change in the contribution rate.			

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	the plan sponsor's contribution rate?				
Grandfathered Health Plans	**Q3.** Similarly, multiemployer plans do not always know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. What steps should multiemployer plans take to communicate with contributing employers regarding employer contributions towards coverage?	**A3.** If multiemployer plans and contributing employers follow steps similar to those outlined in Q&A2, above, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the contribution rate has changed.	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Grandfathered Health Plans	**Q4.** Also with respect to multiemployer plan coverage, some multiemployer plans have stated that it is common for such plans to have either a fixed-dollar employee contribution or no employee	**A4.** In this circumstance, if there is no increase in the employee contribution towards coverage and any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered, a change in a contributing employer's contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to cease to be a grandfathered health plan.	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	contribution towards the cost of coverage. In such cases, is it relevant if a contributing employer's contribution rate changes (for example, after making up a funding deficit in the prior year or to reflect a surplus), provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage?				
Grandfathered Health Plans	**Q5.** Are the Departments receiving other comments and questions regarding the grandfather regulations? Is more	**A5.** The Departments invited comments on their interim final grandfather regulations, as well as on the appeals regulations and other provisions whose applicability is affected by status as a grandfathered health plan. The Departments have issued some sub-	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	guidance expected?	regulatory guidance on the appeals regulations and will continue to review and evaluate comments on these and other regulations, and might issue further sub-regulatory guidance on selected issues as comments are evaluated. Final regulations on the various interim final regulations recently issued under the Affordable Care Act are expected to be published beginning next year.			
Grandfathered Health Plans	**Q6.** Will the Departments change the current rules so that a grandfathered group health plan that changes carriers does not relinquish its status as a grandfathered health plan?	**A6.** The Departments anticipate that they will shortly address the circumstances under which grandfathered group health plans may change carriers without relinquishing their status as grandfathered health plans	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Grandfathered Health Plans	**Q7.** My plan already provided an external review process before the Affordable Care Act was enacted. Can my already-existing external review process be deemed to comply with Public	**A7.** If your plan existed prior to enactment of the Affordable Care Act, you should first check to see if your plan is a grandfathered health plan. If it is, the new external review provisions of PHS Act section 2719(b) do not apply to your plan. If your plan is not a grandfathered health plan and it is insured, the Departments have provided transitional	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	Health Service Act (PHS Act) section 2719(b)?	relief under which plans can use existing State external processes, in one of the States in which they operate, to comply with the new Federal requirements. This transitional relief applies regardless of whether the plan already existed on March 23, 2010 or is a new plan. If your plan is not a grandfathered health plan and it is self-insured, relief is also provided. On August 23, 2010, the Department of Labor issued Technical Release 2010-01, which sets forth an enforcement safe harbor. If the plan complies with one of the methods set forth in the release, the Department of Labor and the IRS will not take any enforcement action with respect to PHS Act section 2719(b) during the transition period. See also Q&A8, below.			
Grandfathered Health Plans	**Q8.** What if a self-insured plan's external review process does not satisfy the safe harbor in the DOL technical release?	**A8.** The technical release provides a safe harbor from enforcement by the Departments. For plans that do not strictly comply with all the standards set forth in the technical release, compliance will be determined on a case-by-case basis under a facts and circumstances analysis. Thus, a plan that does not satisfy all of the standards of the technical release's safe harbor may in some circumstances nonetheless be considered to be in compliance with PHS Act section 2719(b).	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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		For example, one of the standards set forth in the technical release requires self-insured plans to contract with at least three independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan's failure to contract with at least three IROs does not mean that the plan has automatically violated PHS Act section 2719(b). Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.			
Grandfathered Health Plans	**Q9.** Similarly, what if a self-insured plan does not contract directly with any independent review organization (IRO), but contracts with a third-party administrator (TPA) that, in turn, contracts with an IRO?	**A9.** The technical release does not require a plan to contract directly with any IRO. Where a self-insured plan contracts with a TPA that, in turn, contracts with an IRO, the standards of the technical release can be satisfied in the same manner as if the plan had contracted directly. Of course, such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with external review. Moreover, fiduciaries of plans that are subject to ERISA have a duty to monitor the service providers to the plan.	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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Grandfathered Health Plans	**Q10.** What if there is no IRO in my plan's State?	**A10.** The IRO is not required to be in the same State as the plan. Plans may contract with an IRO even if it is located in another State.	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Grandfathered Health Plans	**Q11**. The Departments' regulations make changes to shorten the times for making initial determinations with respect to urgent care claims, but did not make any changes to the times for making internal appeals decisions. The Departments' model notice of adverse benefit determination issued on August 23, 2010, was unclear as to which times have been shortened. What is the rule?	**A11**. Only the times for making the initial benefit determination were changed. The Departments have revised the model notice to eliminate confusion. The revised notice includes a header that reads, "Revised as of September 20, 2010".	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Grandfathered Health Plans	**Q12.** I anticipate that my plan will no longer be a grandfathered plan and will have a hard time making systems	**A12.** Yes, on September 20, 2010 the Department of Labor issued Technical Release 2010-02 at http://www.dol.gov/ebsa/newsroom/tr10-02.html providing an enforcement grace period until July 1, 2011 to give	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	changes in time to comply with some of the new standards for claims and internal appeals. Is there any relief?	plans and issuers necessary time to make certain procedural and computer system changes to comply with the new requirements			
Grandfathered Health Plans	**Q13.** The September 20, 2010 technical release, among other things, gives plans and issuers additional time (as an enforcement grace period until July 1, 2011) before they have to provide new content (such as coding information) on notices of adverse benefit determination and notices of final adverse benefit determination. Does this mean that notices are not required during the grace period?	**A13.** No. The Technical Release 2010-02 provides that the standards of the Department of Labor's claims procedure regulation issued on November 21, 2000 (29 CFR 2560.503-1) apply. A grace period is given only for the new content required under paragraph (b)(2)(ii)(E) of the Departments' July 23, 2010 interim final claims and appeals regulations. In addition, under existing regulations, claimants may obtain coding and other information relevant to the claimant's claim for benefits free of charge upon request. See 29 CFR 2560.503-1(h)(2)(iii).	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html
Dependent Coverage and Children	**Q14.** Will a group health plan or issuer fail to satisfy section 2714 of the Public Health Service Act	**A14.** No. A plan or issuer does not fail to satisfy the requirements of PHS Act section 2714 or its implementing regulations because the plan limits health coverage for children until the	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	(PHS Act) and its implementing interim final regulations merely because it conditions health coverage on support, residency, or other dependency factors for individuals under age 26 who are not described in section 152(f)(1) of the Internal Revenue Code (Code)? (That section of the Code defines children to include only sons, daughters, stepchildren, adopted children (including children place for adoption), and foster children.)	child turns 26 to only those children who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.			
Out-of- Network Emergency Services	**Q15.** Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency	**A15.** No. As stated in the preamble to the interim final regulations under section 2719A, the minimum payment standards set forth in paragraph (b)(3) of the regulations were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. If a State law prohibits balance billing, plans and issuers are not required to	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. At the same time, the statute does not require plans or issuers to cover amounts that out-of-network providers may "balance bill". Accordingly, the interim final regulations under section 2719A set forth minimum payment standards in paragraph (b)(3) to	satisfy the payment minimums set forth in the regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if State law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.			

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	ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient. Are the minimum payment standards in paragraph (b)(3) of the regulations intended to apply in circumstances where State law prohibits balance billing? (Similarly, what if a plan or issuer is contractually obligated to bear the cost of any amounts balance billed, so that the patient is held harmless from those costs?)				
Highly Compensated Employees	**Q16.** Are the Departments planning to issue any guidance regarding the provisions of Public Health Service Act (PHS	**A16.** Yes, on September 20, 2010 the Internal Revenue Service released Notice 2010-63, to be published in Internal Revenue Bulletin 2010-41, October 12, 2010 at http://www.irs.gov/pub/irs-drop/n-10-63.pdf. This bulletin provides	ACA Implementation FAQ #1	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs.html

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	Act) section 2716 (which prohibits discrimination in favor of highly compensated individuals in insured group health plans)?	background information on the statutory provisions of PHS Act section 2716 that has been reviewed and approved by the three Departments. In addition, it invites comments to be considered in the development of future guidance.			
Grandfathered Health Plans	**Q1.** Our company sponsors a group health plan for our employees that has been in effect since March 23, 2010. We and the issuer of the policy under the plan are considering whether we could make various changes to the plan without losing grandfathered status. If we avoid making any of the six specific changes described in paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, are there other changes to our existing plan/policy that we need to be concerned	**A1.** No. Paragraph (g)(1) of the Departments' interim final grandfather regulations provides that any of six changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status. Briefly stated, these six changes are: 1. Elimination of all or substantially all benefits to diagnose or treat a particular condition. 2. Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%). 3. Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points. 4. Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation). 5. Decrease in an employer's contribution rate towards the cost of	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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	could cause it to relinquish grandfathered status? [1]	coverage by more than 5 percentage points. 6. Imposition of annual limits on the dollar value of all benefits below specified amounts For a plan that is continuing the same policy, these six changes are the only changes that would cause a cessation of grandfather status under the interim final regulations. (As noted, the Departments are separately considering under what circumstances otherwise grandfathered plans may change issuers without relinquishing their status as grandfathered health plans.)			
Grandfathered Health Plans	**Q2.** My plan offers three benefit package options – a PPO, a POS arrangement, and an HMO. If the HMO relinquishes grandfather status, does that mean that the PPO and POS arrangement must also relinquish grandfather status?	**A2.** No. The grandfather analysis applies on a benefit-package-by-benefit-package basis. In this situation, it is permissible to treat the PPO, POS arrangement, and HMO as separate benefit packages. Accordingly, if any benefit package ceases grandfather status, it does not affect the grandfather status of the other benefit packages	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html
Grandfathered Health Plans	**Q3.** How do the Departments' interim final grandfather rules regarding changes in employer	**A3.** The interim final grandfather regulations provide that the standards of paragraph (g)(1)(v) for employer contributions (listed above as item (5) in Q&A-1) apply on a tier-by-tier	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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	contributions apply where an employer restructures its tiers of coverage?	basis. As a result, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March 23, 2010. In this example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50% (i.e., at least 45 percent). If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)**(1).** Therefore, for example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.			
Grandfathered Health	**Q4.** If an employer	**A4.** Yes. Each change in cost sharing is	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Plans	plan sponsor raises the copayment level for a category of services (such as outpatient or primary care) by an amount that exceeds the standards set forth in paragraph (g)(1) of the interim final regulations, but retains the copayment level for other categories of services (such as inpatient care or specialty care), will that cause the plan to relinquish grandfather status?	separately tested against the paragraph (g)(1) standards of the Departments' interim final grandfather regulations	Implementation FAQ #2		act-Sheets-and-FAQs/aca_implementation_faqs2.html
Grandfathered Health Plans	**Q5.** How do the Departments' interim final grandfather regulations affect wellness programs sponsored by group health plans?	**A5.** Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries, by rewarding high quality providers, and by incorporating evidence-based treatments into benefit plans. [2] However, penalties (such as cost-sharing surcharges) may implicate the paragraph (g)(1) standards listed above in Q&A-1 and should be examined carefully. In addition, plans should take steps to ensure compliance	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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		with applicable nondiscrimination rules (such as the HIPAA [3] nondiscrimination rules for group health plans and group health insurance coverage with respect to an individual based on a health status related factor) and any other applicable Federal or State law.			
Dental & Vision Benefits	**Q6.** What if my dental (or vision) benefits are structured as excepted benefits under HIPAA? Does that exemption except my dental (or vision) plan from the Affordable Care Act's market reforms?	**A6.** Yes. If benefits constitute excepted benefits under HIPAA, the requirements of the Affordable Care Act's market reforms do not apply. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they: ■Are offered under a separate policy, certificate, or contract of insurance; or ■Are not an integral part of the plan. For dental (or vision) benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium. Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision) benefits would constitute excepted benefits, and the market reform provisions would not apply to that coverage.	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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Rescissions	**Q7.** The Affordable Care Act (through Public Health Service Act section 2712) generally provides that plans and issuers must not rescind coverage unless there is fraud or an individual makes an intentional misrepresentation of material fact. A rescission is defined as it is commonly understood under the law – a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage. Is the exception to the statutory ban on rescission limited to fraudulent or intentional misrepresentations about prior medical history? What about retroactive terminations of	**A7.** The statutory prohibition related to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. An example in the Departments' interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee. On the other hand, some plans and issuers have commented that some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission. Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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	coverage in the "normal course of business"?	the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.)			
Preventive Health Services	**Q8.** Some of the recommendations and guidelines of the United States Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) and the Health Resources and Services Administration (HRSA) do not definitively state the scope, setting, or frequency of the items or services to be covered. What	**A8.** The interim final regulations regarding preventive health services provide that if a recommendation or guideline for a recommended preventive health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques (which generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or similar practices) to determine any coverage limitations under the plan. Thus, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and these established techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service.	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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	should my plan do if an individual requests, for example, daily counseling for diet?				
Clarification Relating to Policy Year & Effective Date of the Affordable Care Act for Individuals Health Insurance Policies	**Q9.** Some States and issuers have interpreted the definition of a policy year in the interim final regulation on dependent coverage of children to age 26 [4] to mean that if an issuer establishes a policy year for the insured under an individual policy on a basis other than the effective date of coverage (such as a calendar year beginning January 1, 2012), then the provisions of the Affordable Care Act do not apply to those policies before the start of the policy year. Can compliance with the Affordable Care Act requirements for policies in the	**A9.** No. We understand that carriers in the health insurance individual market may designate a fixed policy year, but continue to issue policies throughout the year. For example, a carrier may designate a policy year of January 1 through December 31 for an individual policy under which coverage begins on October 1. However, the statute and regulations contemplate implementation of the Affordable Care Act requirements at the beginning of the first new period of coverage that begins on or after September 23, 2010, whether this new coverage period is a full or shortened period of coverage. If a policy begins to cover an individual effective on a date that is on or after September 23, 2010, the initial policy year for that individual, for purposes of determining the effective date of the Affordable Care Act requirements, begins on the first date on which the coverage is effective. This initial period of coverage might be an abbreviated policy year. For example, it may run from October 1, 2010 through December 31, 2010, with a new calendar-based policy	ACA Implementation FAQ #2	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs2.html

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	individual market sold on or after September 23, 2010 be effective on a date other than the date that coverage begins?	year beginning on January 1, 2011 (assuming the individual renews the policy), or from December 1, 2010 through June 30, 2011, with a new policy year beginning each July 1 (again, assuming the policy is renewed). It would be a "policy year" for purposes of the Affordable Care Act effective date if it is a new period of coverage, regardless of when (or whether) the first subsequent 12 month policy year begins. If issuers, however, have relied in good faith on guidance or instructions from a state insurance regulator indicating that the provisions of the Affordable Care Act are not applicable until the beginning of the first full policy year of the individual coverage, then carriers will be afforded a reasonable period of time after the issuance of this guidance to come into compliance with the law. Nonetheless, subsequent to the issuance of this guidance, issuers may not rely in good faith on any contrary guidance or instruction issued by a state insurance regulator.			
Exemption for Group Health Plans with Less than Two Current Employees	**Q1.** Do the HIPAA statutory exemptions in effect since 1997 for group health plans with "less than two participants who are current	**A1.** Yes. The preamble to the interim final regulations on grandfathered plans [1] noted that statutory provisions in effect since 1997 exempting group health plans with "less than two participants who are current employees" from HIPAA also exempt such plans	ACA Implementation FAQ #3	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html

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	employees" apply to the Affordable Care Act's group market reforms?	from the group market reform requirements of the Affordable Care Act. Accordingly, under the terms of these statutory provisions, group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate) are exempt from the Affordable Care Act's market reform requirements.			
Exemption for Group Health Plans with Less than Two Current Employees	**Q2.** I am an employer who sponsors a number of plans including one for both my retirees and individuals on long-term disability. Before the Affordable Care Act, we treated our plan covering retirees and those on long-term disability as exempt under HIPAA. Can we continue to treat that plan as exempt?	**A2.** The Departments have not issued guidance on this specific issue. In order to fully analyze the issue, and balance the goal of ensuring that the Affordable Care Act's market reforms and patient protections are provided to eligible enrollees of group health plans with the goal of preventing disruption of existing coverage, the Departments will be issuing a request for information (RFI) very soon. The RFI will solicit comments from employers and other stakeholders to inform future guidance. After reviewing the comments submitted, the Departments intend to publish guidance on this issue in 2011. Until guidance is issued, the Departments will treat plans described above as satisfying the exemption from HIPAA and the Affordable Care Act's group market reforms for plans with less than two participants who are current employees. To the extent future	ACA Implementation FAQ #3	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs3.html

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		guidance on this issue is more restrictive with respect to the availability of the exemption than this interim relief, the guidance will be prospective, applying to plan years that begin some time after its issuance. Pending such further guidance, a plan may adopt any or all of the HIPAA and Affordable Care Act market reform requirements without prejudice to its exemption. The Departments encourage such voluntary compliance.			
Grandfathered Health Plans	**Q1.** The Departments' interim final grandfather regulations provide that, to maintain status as a grandfathered health plan, a group health plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage	**A1.** A grandfathered health plan will comply with this disclosure requirement if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. While it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of	ACA Implementation FAQ #4	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html

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	believes it is a grandfathered health plan. Must a grandfathered health plan provide the disclosure statement every time it sends out a communication, such as an EOB (explanation of benefits), to a participant or beneficiary? If not, how does a grandfathered health plan comply with this disclosure requirement?	grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.			
Grandfathered Health Plans	**Q2.** If an individual health insurance policy that was in place on March 23, 2010 included a feature that allowed a policy holder to elect an option under which he or she would pay a reduced premium in exchange for higher cost sharing, could such an election be made after March 23	**A2.** Yes. The cost-sharing level that would apply under this option would be grandfathered as part of the policy in place on March 23, 2010 even if it did not apply for the particular individual at that time. As long as the policy holder had that option available on March 23 under the policy, he or she could exercise the option after March 23 without affecting grandfather status, even if the result would be that the particular individual's cost-sharing would increase as a result of electing this option by an amount in excess of the grandfather rule limits.	ACA Implementation FAQ #4	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html

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	without affecting the policy's grandfather status even if the increase in cost sharing for the individual would exceed the limits under the grandfather rule on increases in cost sharing?				
Grandfathered Health Plans	**Q3.** An employer has maintained a plan since before enactment of the Affordable Care Act that reimburses expenses for special treatment and therapy of eligible employees' children with physical, mental, or developmental disabilities. The treatment or therapy is not covered by the employer's primary medical plan or plans. Reimbursable expenses may include expenses for special treatment or therapy from licensed clinics or	**A3.** Yes. In accordance with the preamble to the Departments' interim final regulations implementing PHS Act section 2711, for plan years beginning before the issuance of final regulations defining "essential health benefits," for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." (Of course, the regulations may differ in their definition of "essential health benefits" from reasonable interpretations used before the regulations are issued.) Accordingly, in the case of plans described above, for such plan years: (i) the Departments will treat as a reasonable good faith interpretation of section 2711 of the PHS Act and the regulations thereunder the position that the imposition of the per-child lifetime dollar limit on benefits provided under such plans does not violate the lifetime limit prohibition,	ACA Implementation FAQ #4	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs4.html

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	practitioners, day or residential special care facilities, special education facilities for learning-disabled children, or camps offering medically oriented programs that are part of a child's continued treatment, or for special devices. The plan is operated separately from the employer's primary medical plans; employees who are otherwise eligible may participate in the plan without participating in those primary medical plans. The plan limits the total benefits for any eligible child to a specified lifetime dollar limit. Would it be a reasonable good faith interpretation of the Affordable Care Act and the regulations thereunder for the plan sponsor to take	and (ii) the imposition by such plans of such a limit will not result in an enforcement action by the Departments against such plans under PHS Act section 2711.			

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	the position that the plan does not violate the prohibition, under section 2711 of the Public Health Service Act (PHS Act) and the related interim final regulations, on imposing a lifetime dollar limit on "essential health benefits," as defined in section 1302(b) of the Affordable Care Act (the lifetime limit prohibition)?				
Value Based Insurance Design In Connection with Preventive Care Benefits	**Q1.** My group health plan does not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting would generally require a $250 copayment. Is this permissible	**A1.** Yes, this plan design is permissible. PHS Act section 2713 and its implementing regulations allow plans to use reasonable medical management techniques to control costs. The regulations the Departments issued to implement the preventive health benefits in the Affordable Care Act recognized the important role that VBID can play in promoting the use of appropriate, high value preventive services and providers. Plans may use reasonable medical management techniques to steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services, provided the	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	under PHS Act section 2713?	plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by having a mechanism for waiving the otherwise applicable copayment for the preventive services provided in a hospital.			
Automatic Enrollment in Health Plans	**Q2.** The Affordable Care Act amended the Fair Labor Standards Act (FLSA) by adding a new section 18A, requiring employers with more than 200 full-time employees to automatically enroll new full-time employees in the employer's health benefits plans and continue enrollment of current employees. What Agency is responsible for guidance under this new FLSA provision?	**A2.** The Secretary of Labor has delegated responsibility for FLSA section 18A rulemaking, and for regulations under new section 18B of the FLSA, Notice to Employees of Coverage Options, to the Employee Benefits Security Administration (EBSA) within the Department of Labor. EBSA and the Department of the Treasury will coordinate to develop the rules that will apply in determining full-time employee status for purposes of the amendments to the FLSA and the rulemaking by the Treasury Department under the Internal Revenue Code to develop the rules that will apply in determining full-time employee status for purposes of the amendments made by the Affordable Care Act to the Internal Revenue Code.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	Q3. When do employers have to comply with the new automatic enrollment requirements in section 18A of the FLSA?	**A3.** Section 18A provides that employer compliance with the automatic enrollment provisions of that section shall be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]." Accordingly, it is the view of the Department of Labor that, until such regulations are issued, employers are not required to comply with section 18A. The Department of Labor expects to work with stakeholders to ensure that it has the necessary information and data it needs to develop regulations in this area that take into account the practices employers currently use for auto-enrollment and to solicit the views and practices of a broad range of stakeholders, including employers, workers, and their families. The Department of Labor intends to complete this rulemaking by 2014.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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Disclosure under PHS Act Section 2715 (d)(4)	**Q4.** When are group health plans and health insurance issuers required to comply with the notice requirement in PHS Act section 2715 (d)(4), which generally requires a 60-day prior notice for material modifications to the plan or coverage?	**A4.** PHS Act section 2715 as added by the Affordable Care Act generally provides, among other things, that not later than 12 months after the date of enactment of the Affordable Care Act, the Departments must develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage and, not later than 24 months after the date of enactment, plans and issuers must begin to provide the summary pursuant to the standards. PHS Act section 2715(d)(4) generally provides that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act (ERISA)) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Accordingly, it is the view of the Departments that group health plans and health insurance issuers are not required to comply with the 60-day prior notice	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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		requirement for material modifications in PHS Act section 2715 (d)(4) until plans and issuers are required to provide the summary of benefits and coverage explanation pursuant to the standards issued by the Departments.(1) The Departments have not yet issued the standards.			
Dependent Coverage of children to Age 26	**Q5**. My group health plan normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses, and dependent children, but waives it for those under age 19. Is this permissible?	**A5**. Yes. The Departments' regulations implementing PHS Act section 2714 provide that the terms of a group health plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). While this generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this case, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the Departments will not consider the arrangement described in this question (including waiver, for individuals under age 19, of the generally applicable copayment) to violate PHS Act section 2714 or its implementing regulations.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html
Preexisting Condition Exclusions for Children in	**Q6**. Some States have expressed an	**A6.** Yes, under certain circumstances, issuers may screen applicants for	ACA Implementation	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-

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the Individual Market	interest in permitting issuers to screen applicants for eligibility for alternative coverage options before offering a child-only policy. Is this allowed?	eligibility for alternative coverage options before offering a child-only policy, provided this practice is permitted under State law. Screening is limited to circumstances in which all child-only applicants, regardless of health status, undergo the same screening process, and the alternative coverage options include options for which healthy children would potentially be eligible, such as the Children's Health Insurance Program (CHIP) and group health insurance. Screening may not be limited to programs targeted to individuals with a pre-existing condition, such as the state high risk pool or Pre-existing Condition Insurance Plan (PCIP). Note that Medicaid policy, under 42 U.S.C.A. § 1396a (25)(G), prohibits participating States from allowing health issuers to consider whether an individual is eligible for, or is provided medical assistance under, Medicaid in making enrollment decisions. Furthermore, issuers may not implement a screening process that by its operation significantly delays enrollment or artificially engineers eligibility of a child for a program targeted to individuals with a pre-existing condition. Additionally, the screening process may not be applied to offers of dependent coverage for children given the new Affordable Care Act	FAQ #5		FAQs/aca_implementation_faqs5.html

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		requirement of offering coverage to dependents up to age 26. States are encouraged, subject to State law, to require issuers that screen for other coverage to enroll and provide coverage to the applicant effective on the first date that the child-only policy would have been effective had the applicant not been screened for an alternative coverage option. States are also encouraged to impose a reasonable time limit, such as 30 days, at which time the issuer would have to enroll the child regardless of pending applications for other coverage. Finally, nothing in this FAQ should be construed to relieve the issuer of its obligation to enroll a child applicant in coverage.			
Grandfathered Health Plans	**Q7.** My plan terms include out-of-pocket spending limits that are based on a formula (a fixed percentage of an employee's prior year compensation). If the formula stays the same, but a change in earnings results in a change to the out-of-pocket limits such that the change exceeds the	**A7.** No. The Departments have determined that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, that cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases,	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	thresholds allowed under paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, will my plan relinquish grandfather status?	then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.			
The Mental Health Parity & Addiction Equity Act of 2008	**Q8.** After the amendments made by the Affordable Care Act, are small employers still exempt from the MHPAEA requirements? How is "small employer" defined?	**A8.** Yes, small employers are still exempt. Although there were changes to the definition of "small employer" for other purposes under the Affordable Care Act, ERISA and the Code continue ACA Implementation FAQ #5to define a small employer as one that has 50 or fewer employees. Accordingly, for group health plans and health insurance issuers subject to ERISA and the Code, the Departments will continue to treat group health plans of employers with 50 or fewer employees as exempt from the MHPAEA requirements under the small employer exemption, regardless of any State insurance law definition of small employer. For nonfederal governmental plans, the PHS Act was amended by the Affordable Care Act to define a small employer as one that has 100 or fewer employees.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html
The Mental Health Parity & Addiction Equity Act of	**Q9.** I am an in-network health care	**A9.** Yes. MHPAEA and its implementing regulations state that the	ACA Implementation	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-

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2008	provider and one of my patients is having trouble getting benefits paid for a mental health condition or substance use disorder. Am I entitled to receive a copy of the criteria for medical necessity determinations made by the patient's plan or health insurance coverage?	criteria for medical necessity determinations made under a plan or health insurance coverage with respect to mental health or substance use disorder benefits must be made available by the plan administrator or health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request.	FAQ #5		FAQs/aca_implementation_faqs5.html
The Mental Health Parity & Addiction Equity Act of 2008	**Q10.** I was denied benefits for mental health treatment by my plan because the plan determined that the treatment was not medically necessary. I requested and received a copy of the criteria for medical necessity determinations for mental health and substance use disorder treatment, and the reason for denial. I think my plan is applying medical necessity	**A10.** Under ERISA, documents with information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits are plan documents, and copies of plan documents must be furnished within 30 days of your request. See ERISA regulations at 29 CFR 2520.104b-1. Additionally, if a provider or other individual is acting as a patient's authorized representative in accordance with the Department of Labor's claims procedure regulations at 29 CFR 2560.503-1, the provider or other authorized representative may request these documents. If your plan is not subject to ERISA (for example, a plan maintained by a State or local government), you should check with	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	standards more strictly to benefits for mental health and substance use disorder treatment than for medical/surgical benefits. How can I obtain information on the medical necessity criteria used for medical/surgical benefits?	your plan administrator.			
The Mental Health Parity & Addiction Equity Act of 2008	**Q11.** MHPAEA contains an increased cost exemption. How does a plan claim this exemption?	**A11.** MHPAEA contains an increased cost exemption that is available for plans that make changes to comply with the law and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan (the first plan year beginning after October 3, 2009) or at least one percent in any subsequent plan year (generally, plan years beginning after October 3, 2010). If such a cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year. After that, the plan is required to comply again; however, if the plan incurs an increased cost of at least one percent in that plan year, the plan could claim the exemption for the following plan year. The Departments' interim final	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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		regulations implementing MHPAEA did not provide guidance for implementing the increased cost exemption. Accordingly, during an interim enforcement safe harbor until future regulatory guidance is effective, a plan that has incurred an increased cost of two percent during its first year of compliance can obtain an exemption for the second plan year by following the exemption procedures described in the Departments' 1997 MHPA regulations (62 FR 66932, December 22, 1997)(4), except that, as required under MHPAEA, for the first year of compliance the applicable percentage of increased cost is two percent and the exemption lasts only one year. Calculations of increased costs due to MHPAEA should include increases in a plan's share of cost sharing. Moreover, any non-recurring administrative costs (such as adjustments to computer software) attributable to complying with MHPAEA must be appropriately amortized. Plans applying for an exemption must demonstrate that increases in cost are attributable directly to implementation of MHPAEA and not otherwise to occurring trends in utilization and prices, a random claims experience that is unlikely to persist, or seasonal variation typically experienced in claims submission and payment patterns.			

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Nondiscrimination Based on a Health Factor & Wellness Programs	**Q12**. Are all employment-based wellness programs required to check for compliance with the HIPAA nondiscrimination provisions?	**A12.** No. Many employers offer a wide range of programs to promote health and prevent disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. A wellness program is subject to the HIPAA nondiscrimination rules only if it is, or is part of, a group health plan. If an employer operates a wellness program as an employment policy separate from its group health plan(s), the program may be covered by other Federal or State nondiscrimination laws, but it is not subject to the HIPAA nondiscrimination regulations.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html
Nondiscrimination Based on a Health Factor & Wellness Programs	**Q13.** My group health plan gives an annual premium discount of 50 percent of the cost of employee-only coverage to participants who adhere to a wellness program which consists of attending a monthly health seminar. Does this	**A13.** No. This wellness program is not based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five criteria (set forth above) in the HIPAA nondiscrimination regulations. (The rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage applies only to programs that require satisfaction of a standard related to a health factor in order to qualify for the reward.)	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	reward violate the HIPAA nondiscrimination regulations?				
Nondiscrimination Based on a Health Factor & Wellness Programs	**Q14.** My group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists of giving an annual cholesterol exam to participants; participants who achieve a cholesterol count of 200 or lower receive the annual premium discount. The plan also provides that if it is unreasonably difficult or medically inadvisable to achieve the targeted cholesterol count within a 60-day period, the plan will make available a reasonable alternative standard	**A14.** No. The wellness program is based on a health factor (achieving a cholesterol count of 200 or lower) and is subject to the HIPAA nondiscrimination regulations, including the five criteria described in paragraph (f)(2) of the regulations. In general, among other things, a wellness program subject to the HIPAA nondiscrimination regulations must be available to all similarly situated individuals, provide a reasonable alternative standard, and the reward must be limited to no more than 20 percent of the total cost of coverage. The wellness program described above satisfies the requirement of being available to all similarly situated individuals because the plan provides a reasonable alternative standard and the premium discount is limited to 20 percent of the cost of employee-only coverage.	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	that takes the relevant medical condition into account. Does this wellness program violate the HIPAA nondiscrimination regulations?				
Nondiscrimination Based on a Health Factor & Wellness Programs	**Q15.** My group health plan offers two different wellness programs, both of which are offered to all full-time employees enrolled in the plan. The first program requires participants to take a cholesterol test and provides a 20 percent premium discount for every individual with cholesterol counts under 200. The second program reimburses participants for the cost of a monthly membership to a fitness center. If I participate in both wellness programs and receive both	**A15.** No. In this scenario, the first program is subject to the requirements of the HIPAA nondiscrimination regulations because the premium discount reward is based on an individual satisfying a standard that is related to a health factor (having a cholesterol count under 200). Therefore, the first program must meet the five criteria in the regulations, including the 20 percent limit on the amount of the reward. The second program is not based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five criteria in the regulations. Furthermore, it is permissible to offer both programs at the same time because the rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage only applies to programs that require satisfaction of a standard related to a health factor. As previously noted, the Departments intend to propose regulations that use	ACA Implementation FAQ #5	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs5.html

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	rewards (the 20 percent premium discount and the reimbursement for the cost of a fitness center membership), is my plan violating the HIPAA nondiscrimination regulations?	existing regulatory authority under HIPAA to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30 percent before the year 2014 and are also considering what accompanying consumer protections may be needed to prevent the program from being used as a subterfuge for discrimination based on health status. More guidance is expected early next year.			
Grandfathered Health Plans	**Q1.** What is the scope of the anti-abuse rule in paragraph (b)(2) of the interim final regulations relating to grandfather status? In particular, what is a "bona fide employment-based reason" for employees enrolled in a benefit package that is being eliminated to be transferred into another benefit package?	**A1.** The interim final regulations relating to status as a grandfathered health plan generally state that transferring employees from one grandfathered plan or benefit package (transferor plan) to another (transferee plan) will cause the transferee plan to relinquish grandfather status if amending the transferor plan to replicate the terms of the transferee plan would have caused the transferor plan to relinquish grandfather status. However, the interim final regulations also provide that this rule applies only if there was no bona fide employment-based reason to transfer the employees. For purposes of paragraph (b)(2) of the interim final regulations relating to status as a grandfathered health plan, the Departments interpret the term "bona fide employment-based reason" to embrace a variety of	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html

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		circumstances. These circumstances (under which a transfer would not cause cessation of grandfather status) include, but are not limited to, any of the following: When a benefit package is being eliminated because the issuer is exiting the market; When a benefit package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement); When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package; When a benefit package is eliminated from a multiemployer plan as agreed upon as part of the collective bargaining process; or When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred. The foregoing is not intended to be an exhaustive list of circumstances that will be deemed to satisfy the bona fide employment-based reason condition. There may be many other circumstances in which a benefit package is considered to be eliminated			

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		for a bona fide employment-based reason.			
Grandfathered Health Plans	**Q2.** My plan bases the level of cost sharing for brand-name prescription drugs on the classification of the drugs under the plan as having or not having generic alternatives. The classification of a drug that had no generic alternative changes because a generic alternative becomes available and is added to the formulary, with a resulting increase in the cost-sharing level for the brand-name drug. Does that increase cause my plan to relinquish its grandfather status?	**A2**. No. For example, if, on March 23, 2010, the terms of the plan included prescription drug benefits with different cost sharing divided into tiers as follows: Tier 1 includes generic drugs only; Tier 2 includes brand name drugs with no generic available; Tier 3 includes brand name drugs with a generic available in Tier 1; and Tier 4 includes IV chemotherapy drugs. A drug was previously classified in Tier 2 as a brand name drug with no generic available. However, a generic alternative for the drug has just been released and is added to the formulary. Since the generic is now available, the plan moves the brand name drug into Tier 3 and adds the generic to Tier 1. This movement of the brand name drug into a higher cost-sharing tier does not cause the plan to relinquish grandfather status.	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html
Grandfathered Health Plans	**Q3.** A previous FAQ addressed the interaction of value-based insurance design (VBID) and	**A3.** No. This increase in the copayment for these preventive services solely in the in-network outpatient hospital setting (subject to the waiver arrangement described above) without	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html

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	the no cost-sharing preventive care services requirements. See ACA Implementation FAQs – Set 5. In that example, a group health plan did not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting generally required a $250 copayment, although the copayment was waived for individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting. The FAQ indicated that this VBID did not cause	any change in the copayment in the in-network ambulatory surgery center setting would not be considered to exceed the thresholds described in paragraph (g)(1) of the interim final regulations on grandfather status and thus would not cause the plan to relinquish grandfather status. The Departments are seeking further information on VBID and wellness programs and are planning to address issues relating to those designs and programs in future regulations. Comments from plan sponsors have expressed an interest in being able to retain grandfather status notwithstanding certain changes in plan terms that are intended to implement VBID and wellness programs. As the regulatory process progresses, the Departments will be giving close attention to these comments, and further guidance may be issued addressing other circumstances in which plan changes implementing those designs and programs may be made without relinquishing grandfather status.			

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	the plan to fail to comply with the no cost-sharing preventive care requirements. A question about a different situation has been raised. Under a group health plan, similar preventive services are available both at an in-network ambulatory surgery center and at an in-network outpatient hospital setting, but currently no copayment is imposed for these services in either setting. This has been the case since March 23, 2010. If this plan wished to adopt the VBID approach described in the example above by imposing a $250 copayment for these preventive services only when performed in the in-network outpatient hospital setting (i.e., not when				

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	performed in an in-network ambulatory surgery center), and with the same waiver of the copayment for any individuals for whom it would be medically inappropriate to have these preventive services provided in the ambulatory setting, would implementation of that new design now cause the plan to relinquish grandfather status?				
Grandfathered Health Plans	**Q4.** A plan operating on a calendar plan year is considering an amendment to plan terms that will exceed the thresholds described in paragraph (g)(1) of the interim final regulations and cause it to relinquish grandfather status. If the plan sponsor decides to adopt this amendment on July 1, 2011, and the	**A4.** A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms, which exceeds the thresholds described in paragraph (g)(1) of the interim final regulations, becomes effective – regardless of when the amendment is adopted. Therefore, in this example, the plan would cease to be a grandfathered health plan on January 1, 2012, the first day of the first plan year for which the change is effective.	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html

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	change becomes effective for the plan year beginning on January 1, 2012, at what point in time does the plan relinquish grandfather status?				
Grandfathered Health Plans	**Q5.** A plan operating on a calendar plan year is considering an amendment to plan terms that will cause it to relinquish grandfather status, but wants the amendment to become effective before the first day of the next plan year. If the plan sponsor decides to make this amendment effective on July 1, 2011, does the plan relinquish grandfather status in the middle of the plan year?	**A5.** Yes. A plan or coverage will cease to be a grandfathered health plan when a plan amendment becomes effective. Therefore, if a plan sponsor chooses to make an amendment to plan terms effective in the middle of a plan year, the plan will cease to be a grandfathered health plan at that time. If a plan sponsor wishes to avoid relinquishing grandfathered status in the middle of a plan year, any changes that will cause a plan or coverage to relinquish grandfather status should be made effective the first day of a plan year that begins after the change is adopted.	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html
Grandfathered Health Plans	**Q6.** A plan covers both retirees and active employees and is subject to the	**A6.** In this example, the employer makes contributions based on a formula. Accordingly, the plan will cease to be a grandfathered health plan	ACA Implementation FAQ #6	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs6.html

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	market reform requirements of the Affordable Care Act. For retirees, the employer that sponsors the plan contributes $300 per year multiplied by the individual's years of service for the employer, capped at $10,000 per year. As the cost of coverage increases over time, how is it determined whether the employer's contribution rate has decreased for purposes of maintaining grandfather status?	if the employer decreases its contribution rate towards the cost of coverage by more than five percent below the contribution rate on March 23, 2010. If the formula does not change, the employer is not considered to have reduced its contribution rate, regardless of any increase in the total cost of coverage. However, if the dollar amount that is multiplied by years of service decreases by more than five percent (or if the $10,000 maximum employer contribution cap decreases by more than five percent), the plan will cease to be a grandfathered health plan.			
Summary of Benefits & Coverage & Uniform Glossary Requirements of PHS Act 2715	**Q1.** On August 22, 2011, the Departments issued proposed regulations and proposed templates in connection with implementation of the Summary of Benefits and Coverage and Uniform Glossary	**A1.** The Departments received many comments on the proposed regulations and templates and intend to issue, as soon as possible, final regulations that take into account these comments and other stakeholder feedback. PHS Act section 2715 provides that group health plans and health insurance issuers shall provide the Summary of Benefits and Coverage and Uniform Glossary pursuant to standards developed by the	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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	requirements of PHS Act § 2715. An applicability date "beginning March 23, 2012" was proposed. At the same time, the Departments invited comments generally, as well as on a range of discrete issues, including the timing of the application of the SBC requirement. My plan anticipates that preparation of the summary of benefits and coverage will take several months and require significant resources. In light of the March 23, 2012 proposed applicability date, we are considering moving forward with implementation of the Summary of Benefits and Coverage requirements, using the proposed rules and templates, but	Departments. Accordingly, until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act section 2715. It is anticipated that the Departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.			

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	are concerned that the final rules and templates will differ from the proposed rules and templates, which would prompt additional implementation costs. What is the timeline for the issuance of future guidance on the summary of benefits and coverage? What actions should my plan be taking now, if any?				
Mental Health Parity & Addiction Equity Act of 2008	**Q2:** For all mental health and substance use disorder benefits, my group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary, but the plan does not require such prior authorization for any medical/surgical benefits. Is this permissible?	**A2.** No. The plan is applying a nonquantitative treatment limitation to mental health and substance use disorder benefits that is not applied to medical/surgical benefits. This violates MHPAEA's prohibition on separate treatment limitations that are applicable only to mental health or substance use disorder benefits.	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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Mental Health Parity & Addiction Equity Act of 2008	**Q3:** My group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given for only one day, after which a treatment plan must be submitted by the	**A3.** No. The plan is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits. While some differences in prior authorization practices with respect to individual conditions or treatments might be permissible based on recognized clinically appropriate standards of care, the interim final regulations do not permit a plan to apply stricter nonquantitative treatment limitations to all benefits for mental health or substance use disorders than those applied to all medical/surgical benefits. The application of nonquantitative treatment limitations -- both with respect to the plan's benefits and its care management practices -- must comply with the nonquantitative treatment limitation rules.	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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	patient's attending provider and approved by the plan. Is this permissible?				
Mental Health Parity & Addiction Equity Act of 2008	**Q4:** My group health plan considers a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on	**A4.** Yes. It appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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	application of these factors in a comparable fashion, prior authorization is required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, under my plan, prior authorization is required for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics				

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	prescribed for more than seven days; and all inpatient services beyond 30 days. The evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented. Has my plan complied with the nonquantitative treatment limitation rules?				
Mental Health Parity & Addiction Equity Act of 2008	**Q5.** I am an employer considering several health insurance policy options. One	**A5**. While some differences in plan requirements for prior authorization might be permissible based on recognized clinically appropriate standards of care, it is unlikely that the	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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	health insurance policy requires prior authorization for all outpatient mental health benefits but only a few types of outpatient medical/surgical benefits (outpatient surgery; speech, occupational and physical therapy; and skilled home nursing visits.) Is this permissible?	processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior authorization would also result in all outpatient mental health and substance use disorder outpatient benefits needing prior authorization.			
Mental Health Parity & Addiction Equity Act of 2008	**Q6:** A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorder conditions, but only 30 percent of medical/surgical conditions. Is this permissible?	**A6.** Yes. The evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html

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Mental Health Parity & Addiction Equity Act of 2008	**Q7.** Is my group health plan always limited in the amount that it can charge for all mental health/substance use disorder providers to the same rate as medical/surgical generalists?	**A7.** No. The standard for determining the maximum copayment that can be applied to mental health/substance use disorder benefits is determined by the predominant copayment that applies to substantially all medical/surgical benefits within a classification. If the copayment that meets this standard is the one charged for a medical/surgical specialist, that copayment can be charged for all mental health/substance use disorder benefits within that classification. On the other hand, if the copayment that meets this standard is the one charged for a medical/surgical generalist, then that is the copayment that can be charged to all mental health/substance use disorder benefits within that classification.	ACA Implementation FAQ #7	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs7.html
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	**Q1.** What is the current timeline for issuing guidance on automatic enrollment under FLSA section 18A?	A1. The Department of Labor has been working with stakeholders to ensure that it has the necessary information and data to develop regulations relating to automatic enrollment, and is sensitive to stakeholder concerns regarding the need for adequate time to comply with any regulations that are ultimately issued. In addition, the Department of Labor is aware of the need to coordinate the work it will be undertaking to develop guidance relating to automatic enrollment with the guidance being	FAQ Feb. 9, 2012	CMS	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf

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		developed regarding other related Affordable Care Act provisions, including the employer shared responsibility provision and the 90-day limitation on waiting periods, described above. In view of the need for coordinated guidance and a smooth implementation process, including an applicability date that gives employers sufficient time to comply, the Department of Labor has concluded that its automatic enrollment guidance will not be ready to take effect by 2014. It			
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	Q2. Do Treasury and the IRS intend to issue proposed regulations or other guidance permitting employers to use an employee's W-2 wages as a safe harbor in determining the affordability of employer coverage, as outlined in IRS Notice 2011-73?	A2. Yes. As described in Notice 2011-73, Treasury and the IRS intend to issue proposed regulations or other guidance permitting employers to use an employee's Form W-2 wages (as reported in Box 1) as a safe harbor in determining the affordability of employer coverage.	FAQ Feb. 9, 2012	CMS	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	Q3. Do Treasury and the IRS intend to issue proposed regulations or other guidance addressing how the employer	A3. Yes. Treasury and the IRS intend to issue proposed regulations or other guidance under Code section 4980H (which imposes shared responsibility on large employers with respect to coverage of full-time employees). That	FAQ Feb. 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf

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	shared responsibility provisions under Code section 4980H and the 90-day waiting period limitation under PHS Act section 2708 are coordinated?	guidance is expected to address the intersection of the Code section 4980H rules and the PHS Act section 2708 rules applicable to the 90-day waiting period limitation and will be coordinated with upcoming tri-Department proposed rules under PHS Act section 2708 (discussed below). Treasury and the IRS are mindful of employers' requests for safe harbors and simplicity and will seek to accommodate those requests to the extent feasible and consistent with the terms of the statute. The upcoming guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer responsibility payment under Code section 4980H.			
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	**Q4**. For purposes of determining whether an employee (other than a newly-hired employee) is a full-time employee for purposes of Code section 4980H, do Treasury and the IRS intend to issue proposed regulations or other guidance	**A4.** Yes. Having reviewed the comments in response to IRS Notice 2011-36, Treasury and the IRS intend to issue proposed regulations or other guidance that would allow employers to use a "look-back/stability period safe harbor" method based on the approach outlined in the Notice for purposes of determining whether an employee (other than a newly-hired employee) is a full-time employee. Accordingly, it is anticipated that the guidance will allow	FAQ Feb. 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf

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	allowing employers to use a look-back/stability period safe harbor, based on the approach outlined in IRS Notice 2011-36?	look-back and stability periods not exceeding 12 months. For a description of anticipated guidance regarding newly-hired employees, see Q&A-5.			
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	**Q5.** For purposes of determining whether a newly-hired employee is a full-time employee, do Treasury and the IRS intend to issue proposed regulations or other guidance under Code section 4980H?	**A5.** Yes. Treasury and the IRS also intend to issue proposed regulations or other guidance that will address how to determine whether a newly-hired employee is a full-time employee for purposes of Code section 4980H. As stated in Q&A-3, the upcoming guidance is expected to provide that, at least for the first three months following an employee's date of hire, an employer that sponsors a group health plan will not, by reason of failing to offer coverage to the employee under its plan during that three-month period, be subject to the employer responsibility payment under Code section 4980H. The guidance is also expected to provide that, in certain circumstances, employers have six months to determine whether a newly-hired employee is a full-time employee for purposes of section 4980H and will not be subject to a section 4980H payment during that six-month period with respect to that employee. Treasury and the IRS intend to propose an approach under which the period of time that an employer will have to determine whether a newly-	FAQ Feb. 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf

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		hired employee is a full-time employee (within the meaning of section 4980H) will depend upon whether, based on the facts and circumstances, (a) the employee is reasonably expected as of the time of hire to work an average of 30 or more hours per week on an annual basis and (b) the employee's first three months of employment are reasonably viewed, as of the end of that period, as representative of the average hours the employee is expected to work on an annual basis. Specifically, it is intended that the upcoming proposed regulations or other guidance would provide, for purposes of section 4980H, that: • If a newly-hired employee is reasonably expected to work full-time on an annual basis and does work full-time during the first three months of employment, the employee must be offered coverage under the employer's group health plan as of the end of that period in order to avoid the possibility that the employer would be subject to a section 4980H payment after the end of that three-month period. • If, based on the facts and circumstances as of the time of hire, it cannot reasonably be determined that a newly-hired employee is expected to work full-time, the following rules will			

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		apply for purposes of determining whether the newly-hired employee is considered a full-time employee in applying section 4980H with respect to the employer's group health plan: • If the employee works full-time during the first three months of employment, and the employee's hours during that period are reasonably viewed, as of the end of that period, as representative of the average hours the employee is expected to work on an annual basis, the employee will first be considered a full-time employee for purposes of section 4980H as of the end of that three-month period. (If the employee works part-time during the first three months of employment, then no section 4980H penalty applies during the first or second three month period.) • If the employee works full-time during the first three months of employment, but the employee's hours during that period are reasonably viewed, as of the end of that period, as not representative of the average hours the employee is expected to work on an annual basis, the plan is permitted an additional three-month period to determine the employee's status, and no section 4980H payment would be required with respect to that employee during the first or second three-month periods. (If the			

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		employee works part-time during the second three months of employment, then no section 4980H penalty applies during the first, second, or third three-month period.) This policy describes the applicability of a potential section 4980H payment with respect to newly-hired employees. Forthcoming guidance is expected also to coordinate the rules for newly-hired employees with those applicable to other employees (including employees who are transferred from one employment classification or status to another). The following examples illustrate the intended approach described above: **Example 1: Newly-hired employee expected to work full time.** **Facts:** Employer D, an applicable large employer (i.e., an employer with at least 50 full-time equivalent employees), hires Employee X as a computer programmer on December 1. Employee X is expected to work full-time on an annual basis and does work full-time for the months of December, January, and February. Employer D offers health coverage to its full-time workers (and their dependents). **Conclusion:** Employee X must be able to enroll in coverage beginning in			

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		March or the employer potentially would be subject to a section 4980H payment. However, failure to offer coverage to Employee X during the first three months (December-February) would not subject Employer D to a potential section 4980H payment. **Example 2: Newly-hired employee who seasonally works full-time** **Facts:** Same as Example 1 except that Employer D hires Employee Y as a salesperson who is expected to work full-time during the holiday season and part-time the rest of the year. Employee Y works an average of 35 hours per week in December, January, and February and 20 hours per week in March, April, and May. **Conclusion:** If, based on the facts and circumstances at the end of the period, the three-month period of December through February is reasonably viewed as not representative of the average hours Employee Y is reasonably expected to work on an annual basis, Employer D may use a second three-month period (March-May) as a look-back period. Failure to offer coverage under Employer D's group health plan to Employee Y during the first (December-February) and the second (March-May) three-month periods would not subject Employer D to a potential section 4980H payment.			

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		(Failure to offer coverage to Employee Y for June also would not subject Employer D to a potential section 4980H payment because Employee Y was determined to be part-time during the March-May look-back period.)			
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	**Q6.** When PHS Act section 2708 (which imposes a 90-day limitation on waiting periods) becomes effective in 2014, will it require an employer to offer coverage to part-time employees or to any other particular category of employees?	**A6.** No. Many employers make distinctions in eligibility for coverage based on full-time or part-time status, as defined by the employer's group health plan (which may differ from the standard under Code section 4980H). PHS Act section 2708 does not require the employer to offer coverage to any particular employee or class of employees, including part-time employees. PHS Act section 2708 merely prohibits requiring an otherwise eligible employee to wait more than 90 days before coverage is effective. Furthermore, nothing in the Affordable Care Act penalizes small employers for choosing not to offer coverage to any employee, or large employers for choosing to limit their offer of coverage to full-time employees, as defined in the employer shared responsibility provisions.	FAQ Feb. 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf
Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods	**Q7.** How do the Departments intend to address the application of the 90-day waiting period limitation in PHS	**A7.** Having reviewed the comments in response to IRS Notice 2011-36, the Departments intend to retain, for purposes of PHS Act section 2708, the definition in existing regulations that the 90-day waiting period begins when an	FAQ Feb. 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/employer_faq_bulletin_2_9_12_final.pdf

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	Act section 2708 to an offer of coverage by an employer?	employee is otherwise eligible for coverage under the terms of the group health plan. This is the definition of waiting period used for purposes of Title XXVII of the PHS Act, Part 7 of ERISA, and chapter 100 of the Code.6 Under this approach, if a plan were to provide that full-time employees are eligible for coverage without satisfying any other condition, and an employee were hired as a full-time employee, the waiting period (if the employer were to choose to impose one) for that employee would begin on the date of hire and could not exceed 90 days. Consistent with PHS Act section 2708, eligibility conditions that are based solely on the lapse of a time period would be permissible for no more than 90 days. Other conditions for eligibility under the terms of a group health plan would generally be permissible under PHS Act section 2708, unless the condition is designed to avoid compliance with the 90-day waiting period limitation. For example, eligibility conditions such as full-time status, a bona fide job category, or receipt of a license would be permissible. The upcoming guidance under section 2708 is also expected to address situations in which, under the terms of an employer's plan, employees (or certain classes of employees) are eligible for coverage once they complete			

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		a specified cumulative number of hours of service within a specified period (such as 12 months). It is anticipated that, under the upcoming guidance, such eligibility conditions will not be treated as designed to avoid compliance with the 90-day waiting period limitation so long as the required cumulative hours of service do not exceed a number of hours to be specified in that guidance. Comments are requested on how this possible approach would apply to plans that credit hours of service from multiple different employers and plans that use hours banks. **Example 3: Employee ineligible under terms of plan by reason of job classification** **Facts:** Same as Example 1 except that Employer D's plan does not cover computer programmers. **Conclusion:** Unlike Code section 4980H, in which the determination of full-time status is governed by a statutory standard (working an average of 30 hours per week), the waiting period limitation under PHS Act 2708 applies only to employees who are otherwise eligible under the terms of the plan. Because Employee X is excluded under the plan's eligibility criteria, and the plan's terms are not designed to avoid compliance with PHS Act section 2708, the plan's eligibility provision does not violate PHS Act section 2708.			

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		Example 4: Part-time employee, hours of service requirement **Facts:** Employer E hires Employee Z to work 20 hours per week. Employer E's plan requires part-time employees to complete 750 hours of service in order to participate. Solely for purposes of illustration in this example, it is assumed that upcoming guidance under PHS Act section 2708 permits plans to require part-time employees to complete up to, but no more than, 750 hours of service in order to participate. **Conclusion:** Part-time employees who work 20 hours per week will complete 750 hours of service in 37 ½ weeks or just under 9 months. The waiting period under PHS Act section 2708 begins when Employee Z satisfies the cumulative service requirement, thereby becoming eligible (but for the waiting period) for coverage under the plan. Employer E must provide coverage to Employee Z no later than 90 days after Employee Z completes 750 hours of service, which is about one year after Employee Z is hired and begins working part-time. (No Code section 4980H payment applies because Employee Z is part-time.) **(LINK????)**			
Summary & Benefits & Coverage (SBC)	**Q1.** When must plans and issuers begin providing the SBC?	**A1.** For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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		through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.			
Summary & Benefits & Coverage (SBC)	**Q2.** What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability?	**A2.** The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see http://www.dol.gov/ebsa/faqs/faq-aca.html), is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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		be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices." In addition to the general approach to implementation, in the instructions for completing the SBC, we stated: "To the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program."			

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		Consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations. The Departments intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.			
Summary & Benefits & Coverage (SBC)	**Q3.** Are plans and issuers required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage) within a benefit package?	**A3.** No, plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q4.** If the participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package, are plans and issuers required to provide a separate	**A4.** No, as with the response to Q-3, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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	SBC for every possible combination that a participant may select under that benefit package?	maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC.[2]			
Summary & Benefits & Coverage (SBC)	**Q5.** If a group health plan is insured and utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, who is responsible for providing the SBC with respect to the plan?	**A5.** The Departments recognize that different combinations of plans, issuers, and their service providers may have different information necessary to provide an SBC, including the coverage examples. The Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility (1) to complete the SBC, (2) to provide required information to complete a portion of the SBC, or (3) to deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied: The plan or issuer monitors performance under the contract, If a plan or issuer has knowledge of a	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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		violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable, and If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.			
Summary & Benefits & Coverage (SBC)	**Q6.** If a plan offers participants add-ons to major medical coverage that could affect their cost sharing and other information in the SBC (such as a health flexible spending arrangement (health FSA), health reimbursement arrangement (HRA), health savings account (HSA), or wellness program), is the plan permitted to combine information for all of these add-ons and reflect them	**A6.** Yes. As stated in the preamble to the final regulations and the instructions for completing the SBC template, [3] plans and issuers are permitted to combine such information in one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them. (The Departments' sample completed SBC [4]provides an example of how to denote the effects of a diabetes wellness program.)	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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	in a single SBC?				
Summary & Benefits & Coverage (SBC)	**Q7:** The final regulations require the SBC to be provided in certain circumstances within 7 business days. Does that mean the plan or issuer has 7 business days to send the SBC, or that the SBC must be received within 7 business days?	**A7.** In the context of the final regulations, the term "provided" means sent. Accordingly, the SBC is timely if sent out within 7 business days, even if it is not received until after that period.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q8.** Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?	**A8.** Yes. While a qualifying event does not, itself, trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary). In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary. There are also limited situations in which a COBRA qualified	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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		beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger the right to an SBC. See 26 CFR 54.4980B-5, Q&A-4(b).			
Summary & Benefits & Coverage (SBC)	**Q9.** What circumstances will trigger the requirement to provide an SBC to a participant or beneficiary in a group health plan? In particular, how do the terms "application" and "renewal" apply to a self-insured plan?	**A9.** The final regulations require that the SBC be provided in several instances: Upon application. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage. By first day of coverage (if there are any changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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		Special enrollees. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment). Upon renewal. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.[5] Upon request. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request. Back To Top of page			
Summary & Benefits & Coverage (SBC)	**Q10.** What are the circumstances in which an SBC may be provided electronically?	**A10.** With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries who are eligible but not enrolled for coverage, if:	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html

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		The format is readily accessible (such as in an html, MS Word, or pdf format); The SBC is provided in paper form free of charge upon request; and If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email. An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary who is covered under a plan in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery. With respect to individual market coverage, a health insurance issuer must			

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		provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless: The format is readily accessible; If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible; The SBC is provided in an electronic form which can be retained and printed; and The issuer notifies the individual that the SBC is available free of charge in paper form upon request. In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations. In addition, as stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).			
Summary & Benefits &	**Q11.** Are issuers	**A11.** The deemed compliance provision	ACA	CCIIO	http://www.cms.gov/

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Coverage (SBC)	who have provided individual market plan information to HealthCare.gov in compliance with PHS Act section 2715 and its implementing regulations already?	in the regulation requires issuers in the individual market to provide all of the data elements that are needed to complete the SBC template to HealthCare.gov. If the issuer fails to provide all of the data elements, it would not be deemed to be in compliance with the regulation. Today, HealthCare.gov does not collect all of the elements of an SBC, such as information necessary to complete the coverage examples. However, HHS will collect this information and display it in the format of the SBC template by September 23, 2012, so that providing information to HealthCare.gov fulfills the deemed compliance provision.	Implementation FAQ #8		CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q12:** Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?	**A12.** Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is: Availability of Summary Health Information As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html

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		choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number).			
Summary & Benefits & Coverage (SBC)	**Q13.** The regulations state that in order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Does this mean that the SBC must include a sentence on the availability of language assistance services?	**A13.** Yes, if the notice is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. The final SBC regulations provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met. [6] The claims and appeals regulations outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan or issuer is generally required to provide oral language services in the non-English language, provide notices upon request in the non-English language, and include in all English versions of the notices a statement in the non-English language clearly indicating	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html

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		how to access the language services provided by the plan or issuer. Accordingly, plans and issuers must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections. Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc. Current county-by-county data can be accessed at 2012 Culturally and Linguistically Appropriate Services (CLAS) County Data Even in counties where no non-English language meets the ten percent threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Moreover, nothing in the SBC regulations limits an individual's rights to meaningful access protections under other applicable Federal or State law, including Title VI of the Civil Rights			

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		Act of 1964.			
Summary & Benefits & Coverage (SBC)	**Q14.** Where can plans and issuers find the written translations of the SBC template and the uniform glossary in the non-English languages?	**A14.** Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cms.gov/cciio/programs/consumer/summaryandglossary/index.html.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q15.** Is an SBC permitted to simply substitute a cross-reference to the summary plan description (SPD) or other documents for a content element of the SBC?	**A15.** No, an SBC is not permitted to substitute a reference to the SPD or other document for any content element of the SBC. However, an SBC may include a reference to the SPD in the SBC footer. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q16.** Can a plan or issuer add premium information to the SBC form voluntarily?	**A16.** Yes. If a plan or issuer chooses to add premium information to the SBC, the information should be added at the end of the SBC form.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs8.html

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Summary & Benefits & Coverage (SBC)	**Q17.** Must the header and footer be repeated on every page of the SBC?	**A17.** No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page. The OMB control numbers (which were displayed on the SBC template and the Departments' sample completed SBC to inform plans and issuers that the Departments had complied with the Paperwork Reduction Act) should not be displayed on SBCs provided by plans or issuers.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q18.** For group health plan coverage, may the coverage period in the SBC header reflect the coverage period for the group plan as a whole, or must the coverage period be the period applicable to each particular individual enrolled in the plan?	**A18.** The SBC may reflect the coverage period for the group health plan as a whole. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q19.** Can issuers and plans make minor adjustments to the SBC format, such as	**A19.** Minor adjustments are permitted to the row or column size in order to accommodate the plan's information, as long as the information is	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html

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	changing row and column sizes? What about changes such as rolling over information from one page to another, which was not permitted by the instructions?	understandable. The deletion of columns or rows is not permitted. Rolling over information from one page to another is permitted.			
Summary & Benefits & Coverage (SBC)	**Q20.** Can plan names be generic, such as "Standard Option" or "High Option"?	**A20.** Yes, generic terms may be used.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q21.** Can the issuer's name and the plan name be interchangeable in order?	**A21.** Yes.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q22.** Can barcodes or control numbers be added to the SBC for quality control purposes?	**A22.** Yes, they can be added.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
Summary & Benefits & Coverage (SBC)	**Q23.** Is the SBC required to include a statement about whether the plan is a grandfathered health plan?	**A23.** No, although plans may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html

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Summary & Benefits & Coverage (SBC)	**Q24**. My plan is moving forward to implement the SBC template for the first year of applicability. Are significant changes anticipated for 2014?	**A24.** No. The Departments identified in the preamble to the final regulations certain discrete changes that would be necessary for plan years (or, in the individual market, policy years) beginning after the first year of applicability. These changes include the addition of a minimum value statement and a minimum essential coverage statement, changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits, and the Departments' intent to add additional coverage examples. The Departments are also considering making some refinements consistent with these FAQs and other requests from plans and issuers for clarification and to promote operational efficiencies. No other changes are planned at this time.	ACA Implementation FAQ #8	CCIIO	http://www.cms.gov/ CCIIO/Resources/ Fact-Sheets-and-FAQs /aca_implementation_faqs8.html
NO TITLE	**Q1:** A previous FAQ outlined the circumstances in which an SBC may be provided electronically.[1] Th e FAQ discussed a safe harbor for providing the SBC to participants or beneficiaries covered under the plan who are able to	**A1:** Yes. The Departments have adopted the following additional safe harbor. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. (In addition, for individual market issuers	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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	effectively access documents provided in electronic form at the worksite. Are there any additional safe harbors for electronic delivery of SBCs?	that offer online enrollment or renewal, the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations.)			
NO TITLE	**Q2:** What are the circumstances that will trigger the requirement for an issuer to provide an SBC to an individual applying for coverage in the individual market, or to a group health plan or its sponsor applying for coverage? In particular, how do the terms "upon application" and "first day of coverage (if there are changes)" apply to an individual (or a plan or its sponsor) shopping for coverage?	**A2:** The regulations state that a health insurance issuer must provide the SBC upon application for health coverage. For this purpose, a plan or issuer must provide the SBC as soon as practicable, but no later than seven business days after receiving a substantially complete application for a health insurance product. If an individual, plan, or plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html
NO TITLE	**Q3**: If an individual (or a plan or its sponsor) receives an	**A3:** No. A duplicate SBC is generally not required to be provided at the time of application unless requested by the	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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	SBC prior to application for coverage, must an issuer automatically provide another SBC upon application, if the information required to be in the SBC has not changed?	applicant. However, if by the time the application is filed, there is a change in the information required to be in the SBC, the issuer or plan must update and provide a current SBC to the individual (or plan or its sponsor) as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. Similarly, if an SBC is provided upon application, there is no requirement to provide the SBC again on the first day of coverage, unless there is a change to the information that is required to be in SBC or an SBC is requested by the applicant.			
NO TITLE	**Q4**: Are issuers required to provide SBCs to group health plans (or their sponsors) who are "shopping" for coverage, but have not yet submitted an application for coverage**?**	A4: Yes, but only in certain circumstances. The regulations generally provide that an SBC must be provided upon request for an SBC or "summary information about a health insurance product." The latter phrase is intended to ensure that persons who do not ask exactly for a "summary of benefits and coverage" still receive one when they explicitly ask for a summary document with respect to a specific health product. Other, general questions about coverage options or discussions about health products do not trigger the requirement to provide an SBC. (See also, Q1 regarding electronic delivery options for providing SBCs.)	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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NO TITLE	**Q5:** A previous FAQ stated that an SBC provided in connection with a group health plan may include a reference to the summary plan description (SPD). [2] For SBCs provided in connection with coverage in the individual market, can the SBC refer to other documents associated with the coverage?	**A5:** Yes. While it is not permitted to substitute a reference to any other document for any content element of the SBC, an SBC may include a reference to another document in the SBC footer. In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of other documents in order to supplement or elaborate on that information.	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html
NO TITLE	**Q6:** Are certain electronic features (such as scrolling and expansion of columns) permitted when displaying the SBC electronically?	**A6:** Yes. Minor adjustments are permitted to accommodate the plan's or issuer's information and electronic display method, such as expansion of columns. Additionally, it is permissible to display the SBC electronically on a single webpage, so the viewer can scroll through the information required to be in the SBC without having to advance through pages (as long as a printed version is available that meets the formatting requirements of the SBC). However, the deletion of columns or rows is not permitted when displaying a complete SBC. (For more on minor adjustments, see FAQs Part VIII at	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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		http://www.dol.gov/ebsa/faqs/faq-aca8.html and http://cms.gov/cciio/resources/factsheets/aca_implementation_faqs8.html. Specifically, Q3 and Q4 state that "plans and issuers may combine information …provided the appearance is understandable" and Q19 states that "minor adjustments are permitted…as long as the information is understandable.")			
NO TITLE	**Q7:** Some plans or issuers provide web-based or print materials to illustrate the differences between benefit package options (including comparison charts and broker comparison websites). Is it permissible to "combine" SBCs or SBC elements to provide a side-by-side comparison?	**A7:** Yes. Issuers and plans (and agents and brokers working with such plans) may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals and employers shopping for coverage. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing of several benefit package options. This could be achieved by providing the "deductible row" of the SBC for several benefit packages, but without having to repeat the first one or two columns, as appropriate, of the SBC for each of the benefit packages. However, such a chart, website, or other comparison does not, itself, satisfy the requirements under PHS Act section 2715 and the final regulations to provide the SBC. The full SBC for all the benefit packages included in the	ACA Implementation FAQ #9		http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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		comparison view/tool must be made available in accordance with the regulations and other guidance.			
NO TITLE	**Q8:** Under what circumstances can penalties be imposed for failure to provide the SBC or the uniform glossary?	**A8:** PHS Act section 2715(f) states that an entity is subject to a fine if the entity "willfully fails to provide the information required under this section." As stated in previous FAQs,[3] the Departments' basic approach to ACA implementation is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law." Accordingly, consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to comply.	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html
NO TITLE	**Q9:** For the first	**A9:** Yes. The Departments are	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	year of applicability,[4] can the Departments provide further assistance with regard to the coverage examples, such as a streamlined calculator?	developing a calculator that plans and issuers can use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion; because this approach will be less accurate, it will be allowed as a transitional tool for the first year of applicability.[5] The calculator will allow plans and issuers to input a discrete number of elements about the benefit package. Calculator inputs generally are expected to be taken from data fields used to populate the front portion of the SBC template. (See http://cms.gov/cciio/resources/other/index.html#sbcug for a list of calculator inputs.) The output will be a coverage example that can be added to the corresponding SBC. The Departments will also provide the algorithm that was used to create the calculator. The calculator and algorithm will be posted at http://cms.gov/cciio/resources/other/index.html#sbcug soon.	Implementation FAQ #9		act-Sheets-and-FAQs/aca_implementation_faqs9.html
NO TITLE	**Q10:** A previous FAQ discussed the utilization of "carve-out arrangements" under which a plan or issuer contracts with a service provider to help manage certain benefits under the	**A10:** Unless it contracts otherwise, an issuer has no obligation to provide coverage information for benefits that it does not insure. However, group health plan administrators are responsible for providing complete SBCs with respect to a plan. A plan administrator that uses two or more insurance products provided by separate issuers with respect to a single group health plan	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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	plan or policy.[6] In another type of "carve-out arrangement," a plan sponsor may purchase an insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not even know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans. What are an issuer's obligations to provide an SBC with respect to benefits it does not insure?	may synthesize the information into a single SBC, or may contract with one of its issuers (or other service providers) to perform that function. Due to the administrative challenges of combining benefit package information from multiple issuers, during the first year of applicability, for enforcement purposes, with respect to a group health plan that uses two or more issuers, the Departments will consider the provision of multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple different insurers and that individuals who would like assistance understanding how these products work together may contact the plan administrator for more information (and provide the contact information).[7]			
NO TITLE	**Q11:** A previous FAQ provided a link	**A11:** Written translations in Spanish, Chinese, and Tagalog are now available.	ACA Implementation	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-

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	where written translations for the SBC template and the uniform glossary would be available in the future.[8] Are these translations available?	Navajo translations will be available shortly. For more information, see CCIIO website at http://cms.gov/cciio/programs/consumer/summaryandglossary/index.html	FAQ #9		FAQs/aca_implementation_faqs9.html
NO TITLE	**Q12:** Are health insurance issuers required to provide SBCs for insurance products that are no longer being offered for purchase?	**A12:** The Departments understand that most plans and issuers have to develop new databases and technology systems in order to extract information about coverage terms and provide SBCs. The Departments also understand that, with respect to insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), there is a significant volume of data that is not stored in electronic form or is not stored in an information system that that is compatible with the new electronic systems being developed for the SBC. Accordingly, due to the additional administrative complexities with respect to providing SBCs with respect to closed blocks of business, the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC before September 23, 2013 with respect to an insured product that is no longer being actively marketed for business, provided the SBC is provided no later	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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		than September 23, 2013 (at which time, enrollees and small employers will have new opportunities to compare coverage options available through an Exchange).			
NO TITLE	**Q13:** Expatriate plans and policies face special circumstances and considerations in complying with the SBC requirements. Can the Departments provide any assistance or relief with respect to expatriate coverage?	**A13:** Yes. The Departments recognize that expatriate coverage carries additional administrative costs and barriers in filling out SBCs, including benefit and claims systems that are distinct from those for domestic coverage, which makes compliance more difficult. Therefore, for purposes of enforcement, the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC with respect to expatriate coverage during the first year of applicability.	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html
NO TITLE	**Q14:** Other than the FAQs, are there any updates to the SBC template and related documents on the Departments' websites that I need to know about?	**A14:** Yes. In the diabetes treatment scenario, the version originally posted contained a typographical error, listing the allowed amount for insulin as $11.92, rather than $119.20 – a difference that impacts the total cost of care for diabetes in the coverage example calculations. To correct this error, the Departments have posted updated versions of the SBC template, the sample completed SBC, and the guide for coverage examples calculations – diabetes	ACA Implementation FAQ #9	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs9.html

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		scenario. The updated SBC template and sample completed SBC also include sample taglines for obtaining translated documents, to be included if appropriate consistent with paragraph (a)(5) of the regulations, as well as updated Sample Care Costs amounts for the diabetes coverage example, due to more accurate rounding in making these calculations. Finally, the updated versions include some appearance modifications (such as changes in bolding, underlining, shading, capitalization, margin justification, use of hyphens, and row and column sizing) to ensure the document is accessible to individuals with disabilities, consistent with section 508 of the Rehabilitation Act. Plans and issuers may use either version, or may make similar modifications to their own SBCs, without violating the appearance requirements for an SBC. The updated versions of these documents are labeled "corrected on May 11, 2012" in the lower right corner of the first page and are available at http://www.dol.gov/ebsa/healthreform and http://cms.gov/cciio/home.html. These three documents replace the prior versions issued contemporaneously with the final regulations in February 2012.			
NO TITLE	**Q1:** I am an	**A1:** No. Medicare Advantage benefits	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	employer sponsoring a group health plan. One of the benefit packages is a Medicare Advantage plan. Am I required to provide an SBC for the Medicare Advantage package?	are Medicare benefits (financed by the Medicare Trust fund and equivalent to Medicare A and B benefits, which are set by Congress and regulated by the Centers for Medicare & Medicaid Services (CMS)). They are, therefore, not health insurance coverage and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Pending further guidance, the Departments will not take any enforcement action against a group health plan because it does not provide an SBC with respect to a Medicare Advantage benefit package [1]. This enforcement policy does not affect other disclosure requirements administered by CMS that apply to Medicare Advantage organizations. These separately required disclosures will ensure that enrollees in these plans receive the necessary information about their coverage and benefits. Nor does this policy affect the obligation of group health plans that offer Medicare Advantage benefit options to ensure that SBCs are provided with respect to other benefit packages that they offer.	Implementation FAQ #10		act-Sheets-and-FAQs/aca_implementation_faqs10.html
Notice of Coverage Options Available Through the Exchanges	**Q1:** When do employers have to comply with the new notice requirements in section 18B of the FLSA?	**A1.** Section 18B of the FLSA provides that employer compliance with the notice requirements of that section must be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]." Accordingly, it is	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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		the view of the Department of Labor that, until such regulations are issued and become applicable, employers are not required to comply with FLSA section 18B. The Department of Labor has concluded that the notice requirement under FLSA section 18B will not take effect on March 1, 2013 for several reasons. First, this notice should be coordinated with HHS's educational efforts and Internal Revenue Service (IRS) guidance on minimum value. Second, we are committed to a smooth implementation process including providing employers with sufficient time to comply and selecting an applicability date that ensures that employees receive the information at a meaningful time. The Department of Labor expects that the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for Exchanges. The Department of Labor is considering providing model, generic language that could be used to satisfy the notice requirement. As a compliance alternative, the Department of Labor is also considering allowing employers to satisfy the notice requirement by providing employees with information using the employer coverage template as discussed in the preamble to the			

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		Proposed Rule on Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing (78 FR 4594, at 4641), which will be available for download at the Exchange web site as part of the streamlined application that will be used by the Exchange, Medicaid, and CHIP. Future guidance on complying with the notice requirement under FLSA section 18B is expected to provide flexibility and adequate time to comply.			
Compliance of Health Reimbursement Arrangements with Public Health Service Act (PHS Act) section 2711	**Q2:** May an HRA used to purchase coverage on the individual market be considered integrated with that individual market coverage and therefore satisfy the requirements of PHS Act section 2711?	**A2.** No. The Departments intend to issue guidance providing that for purposes of PHS Act section 2711, an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that provides coverage through individual policies and therefore will violate PHS Act section 2711.	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html
Compliance of Health Reimbursement Arrangements with Public	**Q3:** If an employee is offered coverage that satisfies PHS	**A3.** No. The Departments intend to issue guidance under PHS Act section 2711 providing that an employer-	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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Health Service Act (PHS Act) section 2711	Act section 2711 but does not enroll in that coverage, may an HRA provided to that employee be considered integrated with the coverage and therefore satisfy the requirements of PHS Act section 2711?	sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in that coverage. Any HRA that credits additional amounts to an individual when the individual is not enrolled in primary coverage meeting the requirements of PHS Act section 2711 provided by the employer will fail to comply with PHS Act section 2711.			
Compliance of Health Reimbursement Arrangements with Public Health Service Act (PHS Act) section 2711	**Q4:** How will amounts that are credited or made available under HRAs under terms that were in effect prior to January 1, 2014, be treated?	**A4.** The Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014, consisting of amounts credited before January 1, 2013 and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013 may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with PHS Act section 2711. If the HRA terms in effect on January 1, 2013, did not prescribe a set amount or amounts to be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012.	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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Disclosure of Information Related to Firearms	**Q5:** Does PHS Act section 2717(c) restrict communications between health care professionals and their patients concerning firearms or ammunition?	**A5:** No. While we have yet to issue guidance on this provision, the statute prohibits an organization operating a wellness or health promotion program from requiring the disclosure of information relating to certain information concerning firearms. However, nothing in this section prohibits or otherwise limits communication between health care professionals and their patients, including communications about firearms. Health care providers can play an important role in promoting gun safety.	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html
Self-Insured Employer Prescription Drug Coverage Supplementing Medicare Part D Coverage Provided through Employer Group Waiver Plans	**Q6:** Must self-insured prescription drug coverage that supplements the standard Medicare Part D coverage through EGWPs comply with the health coverage requirements?	**A6:** Pending further guidance, the Departments will not take any enforcement action against a group health plan that is an EGWP because the non-Medicare supplemental drug benefit does not comply with the health coverage requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code. This enforcement policy does not affect other requirements administered by the Centers for Medicare & Medicaid Services that apply to providers of such coverage. The Centers for Medicare & Medicaid Services intends to issue related guidance concerning insured coverage that provides non-Medicare supplemental drug benefits shortly.	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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Fixed Indemnity Insurance	**Q7:** What are the circumstances under which fixed indemnity coverage constitutes excepted benefits?	**Q7.** The Departments' regulations provide that a hospital indemnity or other fixed indemnity insurance policy under a group health plan provides excepted benefits only if: The benefits are provided under a separate policy, certificate, or contract of insurance; There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. The regulations further provide that to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. Various situations have come to the attention of the Departments where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar	ACA Implementation FAQ #11		http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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		rates per procedure, and/or prescription drugs at $15 per prescription. In such circumstances, for doctors' visits, surgery, and prescription drugs, payment is made not on a per-period basis, but instead is based on the type of procedure or item, such as the surgery or doctor visit actually performed or the prescribed drug, and the amount of payment varies widely based on the type of surgery or the cost of the drug. Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period)," a policy such as this is not hospital indemnity or other fixed indemnity insurance, and is therefore not excepted benefits. When a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits. The Departments plan to work with the States to ensure that health insurance issuers comply with the relevant requirements for different types of insurance policies and provide consumers with the protections of the Affordable Care Act.			
Payment of PCORI Fees	**Q8**: Does Title I of ERISA prohibit a multiemployer plan's	**A8:** In the case of a multiemployer plan defined in ERISA section 3(37), the plan sponsor liable for the fee would	ACA Implementation FAQ #11	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html

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	joint board of trustees from paying the Code section 4376 fee from assets of the plan?	generally be the independent joint board of trustees appointed by the participating employers and employee organization, and directed pursuant to a collective bargaining agreement to establish the employee benefit plan. Normally, such a joint board of trustees has no function other than to sponsor and administer the multiemployer plan, and it has no source of funding independent of plan assets to satisfy the Code section 4376 statutory obligation. The fee involved is not an excise tax or similar penalty imposed on the trustees in connection with a violation of federal law or a breach of their fiduciary obligations in connection with the plan. Nor would the joint board be acting in a capacity other than as a fiduciary of the plan in paying the fee.[iv] In such circumstances, it would be unreasonable to construe the fiduciary provisions of ERISA as prohibiting the use of plan assets to pay such a fee to the Federal government. Thus, unless the plan document specifies a source other than plan assets for payment of the fee under Code section 4376, such a payment from plan assets would be permissible under ERISA. There may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the			

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		Code section 4376 fee, such as a VEBA that provides retiree-only health benefits where the sponsor is a trustee or board of trustees that exists solely for the purpose of sponsoring and administering the plan and that has no source of funding independent of plan assets. The same conclusion would not necessarily apply, however, to other plan sponsors required to pay the fee under Code section 4376. For example, a group or association of employers that act as a plan sponsor but that also exist for reasons other than solely to sponsor and administer a plan may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan. The Department of Labor would expect that such an entity or association, like employers that sponsor single employer plans, would have to identify and use some other source of funding to pay the Code section 4376 fee.			
Limitations on Cost-Sharing under the Affordable Care Act	**Q1:** Who must comply with the deductible limitations under PHS Act section 2707(b)?	**A1:** The HHS final regulation on standards related to essential health benefits implements the deductible provisions described in section 1302(c)(2) for non-grandfathered [1] health insurance coverage and qualified health plans offered in the small group	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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		market, including a provision implementing section 1302(c)(2)(C) so that such small group market health insurance coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit.[2] With respect to self-insured and large group health plans, as explained in the preamble to the HHS final regulations, the Departments intend to engage in future rulemaking to implement PHS Act section 2707(b). The Departments continue to believe that only plans and issuers in the small group market are required to comply with the deductible limit described in section 1302(c)(2). Public input is welcome in advance of a future rulemaking, which will implement that only plans and issuers in the small group market will be subject to the deductible limit. Please send comments by April 22, 2013 to e.ohpsca-2707.ebsa@dol.gov. Until that rulemaking is promulgated and effective, the Departments have determined that a self-insured or large group health plan can rely on the Departments' stated intention to apply the deductible limits imposed by section 1302(c)**(2) of the Affordable Care Act only on plans and issuers in the small group market.**			

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Limitations on Cost-Sharing under the Affordable Care Act	**Q2:** Who must comply with the annual limitation on out-of-pocket maximums under PHS Act section 2707(b)?	**A2**: As stated in the preamble to the HHS final regulation on standards related to essential health benefits, the Departments read PHS Act section 2707(b) as requiring all non-grandfathered group health plans to comply with the annual limitation on out-of-pocket maximums described in section 1302(c)(1) of the Affordable Care Act.[3] The Departments recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated under section 1302(c)(1), which may require new regular communications between service providers. The Departments have determined that, only for the first plan year beginning on or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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		2707(a) or 2707(b), the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied: (a) The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and (b) To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1). The Departments note, however, that existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) [4] prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical			

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		benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.			
Coverage of Preventive Services	**Q3:** My plan does not have any in-network providers to provide a particular preventive service required under PHS Act section 2713. If I obtain this service out-of-network, can the plan impose cost-sharing?	**A3:** No. While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service. United States Preventive Services Task Force (USPSTF)	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q4:** The USPSTF recommends the use of aspirin for certain men and women when the potential benefit due to a reduction in	**A4:** Aspirin and other OTC recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	myocardial infarctions outweighs the potential harm. Aspirin is generally available over-the-counter (OTC) to patients. Are group health plans and health insurance issuers now required to pay for OTC methods such as aspirin?				
Coverage of Preventive Services	**Q5**: If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, is it permissible for a plan or issuer to impose cost-sharing for the cost of a polyp removal during the colonoscopy?	**A5:** No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive	**Q6:** Does the	**A6:** Yes. HHS believes that the scope	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Services	recommendation for genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing include the BRCA test itself?	of the recommendation includes both genetic counseling and BRCA testing, if appropriate, for a woman as determined by her health care provider. PHS Act section 2713 addresses coverage for evidence-based items or services with a rating of “A” or “B” in the current recommendations of the USPSTF, as well as coverage for preventive care and screenings as provided for in comprehensive guidelines released by HRSA. The USPSTF recommends with a “B” rating that “women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.” The HRSA Guidelines, released by HHS in August 2011, incorporate by reference relevant portions of an Institute of Medicine (IOM) Report, released on July 19, 2011. In some instances, the IOM Committee Report provides additional interpretation of USPSTF recommendations. For the USPSTF BRCA recommendation, the IOM Committee interpreted the recommendation to include “referral for genetic counseling and BRCA testing, if appropriate.” Thus, genetic counseling and BRCA testing, if appropriate, must be made available as a preventive service without cost-sharing.	Implementation FAQ #12		act-Sheets-and-FAQs/aca_implementation_faqs12.html

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Coverage of Preventive Services	**Q7:** Some USPSTF recommendations apply to certain populations identified as high-risk. Some individuals, for example, are at increased risk for certain diseases because they have a family or personal history of the disease. It is not clear, however, how a plan or issuer would identify individuals who belong to a high-risk population. How can a plan or issuer determine when a service should or should not be covered without cost-sharing?	**A7:** Identification of "high-risk" individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high-risk population, and should therefore receive a specific preventive item or service identified for those at high-risk, should be made by the attending provider. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, that service is required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management). *Advisory Committee on Immunization Practices (ACIP)*	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q8:** Which ACIP recommendations are required to be covered without cost-sharing by non-grandfathered group	**A8:** PHS Act section 2713 and the interim final regulations require coverage for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation by the ACIP for routine use. The vaccines	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	health plans and health insurance coverage?	must be covered without cost-sharing requirements when the service is delivered by an in-network provider. The ACIP makes routine immunization recommendations for children, adolescents, and adults that are population-based (e.g., age-based), risk-based (e.g., underlying medical conditions, work-related, or other special circumstances that increase risk of illness), or are catch-up recommendations. In some circumstances, the ACIP makes a recommendation that applies for certain individuals rather than an entire population. In these circumstances, health care providers should determine whether the vaccine should be administered, and if the vaccine is prescribed by a health care provider consistent with the ACIP recommendations, a plan or issuer is required to provide coverage for the vaccine without cost-sharing. New ACIP recommendations will be required to be covered without cost-sharing starting with the plan year (in the individual market, policy year) that begins on or after the date that is one year after the date the recommendation is issued. An ACIP recommendation is considered to be issued on the date on which it is adopted by the Director of the Centers for Disease Control and Prevention (CDC), which is the earlier			

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		of: the date the recommendation is published in the Mortality and Morbidity Weekly Report, or the date the recommendation is reflected in the Immunization Schedules of the CDC. Therefore plans or issuers with respect to a plan can determine annually what vaccines recommended by ACIP must be covered by checking http://www.healthcare.gov/law/features/rights/preventive-care/index.html prior to the beginning of each plan year. *Women's Preventive Services*			
Coverage of Preventive Services	**Q9:** Do the recommendations for women's preventive services in the HRSA Guidelines promote multiple visits for separate services?	**A9:** No. Section 2713 of the PHS Act and its implementing regulations allow plans and issuers to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent this information is not specified in a recommendation or guideline. Although the HRSA Guidelines list services individually, nothing in PHS Act section 2713 or the regulations requires that each service be provided in a separate visit. Efficient care delivery and the delivery of multiple prevention and screening services at a single visit is a reasonable medical management technique, permissible under the regulations. For example, HIV screening and counseling and Sexually Transmitted Infections counseling could	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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		occur as part of a single well-woman visit.			
Coverage of Preventive Services	**Q10**: What is included in a "well-woman" visit?	**A10:** The HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care. The HRSA Guidelines recommend that well-woman visits include preventive services listed in the HRSA Guidelines, as well as others referenced in section 2713 of the PHS Act. HHS understands that additional well-woman visits, provided without cost-sharing, may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. If the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations (that is, without cost-sharing and subject to reasonable medical management).	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q11:** What do health care providers need to know to conduct a screening and	**A11:** Screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	counseling for interpersonal and domestic violence, as recommended in the HRSA Guidelines?	tools including chart prompts. One option is the five-question Abuse Assessment Screening tool available here: (http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf, page 22). Counseling provides basic information, including how a patient's health concerns may relate to violence and referrals to local domestic violence support agencies when patients disclose abuse. Easy-to-use tools such as patient brochures, safety plans, and provider educational tools, as well as training materials, are available through the HHS-funded Domestic Violence Resource Network, including the National Resource Center on Domestic Violence (http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/programs/centers).			
Coverage of Preventive Services	**Q12**: In the discussion of "Identified Gaps" within the Cervical Cancer section of the IOM report, the IOM recognized "co-testing with cytology and high-risk Human Papillomavirus (HPV) DNA testing among women 30 years of age and	**A12:** The HRSA Guidelines recommend high-risk HPV DNA testing for women with normal cytology results who are 30 years of age or older to occur no more frequently than every 3 years.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	older as a strategy to increase screening intervals to every three years." When should the HPV DNA test be administered?				
Coverage of Preventive Services	**Q13:** The HRSA Guidelines include a recommendation for annual HIV counseling and screening for all sexually active women. Is the term "screening" in this context defined as actual testing for HIV?	**A13:** Yes. In this context, "screening" means testing	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q14:** The HRSA Guidelines include a recommendation for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive	**A14:** No. The HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to control costs and promote efficient delivery of care.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	capacity, as prescribed by a health care provider. May a plan or issuer cover only oral contraceptives?	For example, plans may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. However, in these instances, a plan or issuer must accommodate any individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version. This generic substitution approach is permissible for other pharmacy products, as long as the accommodation described above exists.[9] If, however, a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).			
Coverage of Preventive Services	**Q15:** Do the HRSA Guidelines include contraceptive methods that are generally available over-the-counter	**A15:** Contraceptive methods that are generally available OTC are only included if the method is both FDA-approved and prescribed for a woman by her health care provider. The HRSA Guidelines do not include contraception	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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	(OTC), such as contraceptive sponges and spermicides?	for men.[10]			
Coverage of Preventive Services	**Q16:** Do the HRSA Guidelines include services related to follow-up and management of side effects, counseling for continued adherence, and for device removal?	**A16:** Yes. Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are included under the HRSA Guidelines and required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q17:** Are intrauterine devices and implants contraceptive methods under the HRSA Guidelines and therefore required to be covered without cost-sharing?	**A17**: Yes, if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q18:** The USPSTF already recommends breastfeeding counseling. Why is this part of the HRSA Guidelines?	**A18**: Under the topic of "Breastfeeding Counseling" the USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support,	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html

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		counseling, and equipment rental. Accordingly, the items and services described in the HRSA Guidelines are required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management, which may include purchase instead of rental of equipment).			
Coverage of Preventive Services	**Q19:** How are certified lactation consultants reimbursed for their services under the HRSA Guidelines?	**A19:** Reimbursement policy is outside of the scope of the HRSA Guidelines and the Departments' regulations.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Coverage of Preventive Services	**Q20:** Under the HRSA Guidelines, how long after childbirth is a woman eligible for lactation counseling? Are breastfeeding equipment and supplies unlimited?	**A20:** Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. Nonetheless, consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.	ACA Implementation FAQ #12	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html
Expatriate Health Plans	**Q1:** To what extent	**A1.** The Departments recognize that	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	is expatriate group health insurance coverage subject to the provisions of the Affordable Care Act?	expatriate health plans may face special challenges in complying with certain provisions of the Affordable Care Act. In particular, challenges in reconciling and coordinating the multiple regulatory regimes that apply to expatriate health plans might make it impossible or impracticable to comply with all the relevant rules at least in the near term. For example, independent review organizations may not exist abroad, and it may be difficult for certain preventive services to be provided, or even be identified as preventive, when such services are provided outside the United States by clinical providers that use different code sets and medical terminology to identify services. Further, expatriate issuers may face challenges and delays in communicating with enrollees living abroad, and, due to the complex nature of these plans, standardized benefits disclosures can be difficult for issuers to produce. Expatriate health plans may require additional regulatory approvals from foreign governments, and, in some circumstances, it is possible that domestic and foreign law requirements conflict. While the Departments gather further information and analyze these challenges to determine what actions may be appropriate regarding the current requirements under the	Implementation FAQ #13		act-Sheets-and-FAQs/aca_implementation_faqs13.html

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		Affordable Care Act, the Departments have determined that, for plans with plan years ending on or before December 31, 2015, with respect to expatriate health plans, the Departments will consider the requirements of subtitles A and C of Title I of the Affordable Care Act satisfied if the plan and issuer comply with the pre-Affordable Care Act version of Title XXVII of the Public Health Service Act. References to subtitles A and C of Title I of the Affordable Care Act also include the corresponding provisions imported into section 715 of the Employee Retirement Income Security Act (ERISA) and section 9815 of the Internal Revenue Code. For purposes of this temporary transitional relief, an expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage. This definition is also the definition of "expatriate health coverage" under 45 CFR 153.400(a)(1)(iii) during this temporary transitional period (that is, for plans with plan years ending on or before December 31, 2015). Expatriate health plans must, as a condition of this transitional relief,			

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		comply with the pre-Affordable Care Act version of Title XXVII of the PHS Act and other applicable law under ERISA and the Internal Revenue Code, including, for example, the mental health parity provisions, the HIPAA nondiscrimination provisions, the ERISA section 503 requirements for claims procedures, and any reporting and disclosure obligations under ERISA Part 1. The Departments note that coverage provided under an expatriate group health plan is a form of minimum essential coverage under section 5000A of the Internal Revenue Code. The Departments request comments on and information about the unique challenges that expatriate health plans may face in complying with provisions of the Affordable Care Act, including information about which particular types of plans face these challenges and with respect to which particular provisions of the Affordable Care Act. Please send comments by May 8, 2013 to e.ohpsca-expat.ebsa@dol.gov.			
Summary of Benefits and Coverage	**Q1**: What templates should plans and issuers use for the SBCs and the uniform glossary required to be provided after the	**A1:** An updated SBC template (and sample completed SBC) are now available at http://cms.gov/cciio and http://www.dol.gov/ebsa/healthreform. These documents are authorized for use with respect to group health plans and group and individual health insurance	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html

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	first year of applicability?	coverage for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to in this guidance document as "the second year of applicability"). The only change to the SBC template and sample completed SBC is the addition of statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the Internal Revenue Code 1986) and whether the plan or coverage meets the MV requirements (that is, the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs). On page 4 of the SBC template (and illustrated on page 6 of the sample completed SBC), a plan or issuer should indicate in the designated entry on the SBC template that the plan or coverage "does" or "does not" provide MEC and whether the plan or coverage "does" or "does not" meet applicable MV requirements. There are no changes to the uniform glossary. There are also no changes to the Instructions for Completing the SBC (for either group or individual health coverage), "Why This Matters" language for the SBC, or to the coverage examples.			
Summary of Benefits and	**Q2**: Our plan is	**A2:** Yes. To the extent a plan or issuer	ACA	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Coverage	already working on the process of preparing SBCs for issuance in the second year of applicability and it would be an administrative burden to add the new data element to the template at this point in the process. Is any relief available to provide information about MEC and MV without changing the SBC template?	is unable to modify the SBC template for disclosures required to be provided with respect to the second year of applicability, the Departments will not take any enforcement action against a plan or issuer for using the template authorized for the first year of applicability, provided that the SBC is furnished with a cover letter or similar disclosure stating whether the plan or coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV requirement under the Affordable Care Act. The language for these statements is as follows: Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy <u>[does/does not] provide</u> minimum essential coverage.** **Does this Coverage Meet the Minimum Value Standard?** The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This**	Implementation FAQ #14		act-Sheets-and-FAQs/aca_implementation_faqs14.html

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		health coverage [does/does not meet the minimum value standard for the benefits it provides.			
Summary of Benefits and Coverage	**Q3:** A previous FAQ stated that the Departments intended to make changes to the SBC template for 2014 to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits.[4] Have the Departments made any changes related to this requirement?	**A3**: No. As stated earlier, the only change to the SBC template and sample completed SBC is the addition of information to indicate whether the plan or coverage provides MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage meets applicable MV requirements under the Affordable Care Act. Plans and issuers should continue to complete the SBC template consistent with the Instructions for Completing the SBC (for either group or individual health coverage, as applicable) for the *Important Questions* chart that appears on page 1 of the SBC: In the *Answers* column, the plan or issuer should respond "No," where the template asks, "Is there an overall annual limit on what the plan pays?", as plans and issuers are generally prohibited from imposing annual limits on the dollar value of essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014.[5] In the *Why This Matters* column, the plan or issuer must show the following language: "The chart starting on page 2 describes any limits on what the plan	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html

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		will pay for *specific* covered services, such as office visits."[6] Additionally, as applicable, plans and issuers should continue to include information regarding annual or lifetime dollar limits on specific covered benefits as required in the chart starting on page 2 of the SBC (in the *Limitations & Exceptions* column), as described in the Instructions for Completing the SBC (for either group or individual health coverage, as applicable). To the extent a plan or issuer wishes to modify the SBC template for disclosures required to be provided for the second year of applicability to remove this information, the Departments will not take any enforcement action against a plan or issuer for removing the entire row in the *Important Questions* chart on page 1 of the SBC (with the question: "Is there an overall annual limit on what the plan pays?").			
Summary of Benefits and Coverage	**Q4:** A previous FAQ stated that the Departments intended to add additional coverage examples for 2014.[7] Have the Departments made any changes related to this requirement?	**A4**: To help transition to new market changes in 2014, the Departments believe it is prudent to maintain the current coverage examples. Additional coverage examples are not required as part of the SBC at this time. As with the SBC authorized for the first year of applicability, the documents authorized for the second year of applicability continue to require the same two coverage examples authorized for the	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html

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		first year of applicability – having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition).			
Summary of Benefits and Coverage	**Q5:** Safe harbors and other enforcement relief were provided by the Departments related to the requirement to provide an SBC and a uniform glossary for the first year of applicability. Will this relief be extended?	**A5:** Yes. As stated in previous FAQs,[8] the Departments' basic approach to ACA implementation is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law." In recognition of and to ensure a smooth transition to new market changes in 2014, the Departments believe it is prudent to extend the following enforcement relief to apply through the end the second year of applicability: • Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the Departments' basic approach to implementation of the SBC	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html

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		requirements during the first year of applicability);[9] • Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);[10] • Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or uniform glossary);[11] • Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator);[12] and related information related to use of the coverage examples calculator;[13] • Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer's obligation to provide an SBC with respect to benefits it does not insure);[14]and • Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);[15] In addition, the following enforcement relief continues to apply through the second year of applicability, consistent with existing guidance: • The Special Rule contained in			

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		the Instruction Guides for Group and Individual Coverage;[16] • Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);[17] and • Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage).[18] Additionally, Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies "until further guidance is issued." The relief provided in this Affordable Care Act Implementation FAQs Part VIII, Q5 continues to apply, and plans and issuers may rely on this relief at least through the end of 2014. This guidance supersedes any previous subregulatory guidance (including FAQs) stating that enforcement relief for the SBC and uniform glossary requirements is limited to the first year of applicability.			
Summary of Benefits and Coverage	**Q6:** A previous FAQ provided an enforcement safe harbor until September 23, 2013	**A6:** Yes. The relief provided in this FAQ extends this date to September 23, 2014 for plans and issuers with respect to an insured product that meets three conditions:	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html

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	for plans and issuers with respect to insurance products that are no longer being offered for purchase ("closed blocks of business").[19] Will this relief be extended?	• The insured product is no longer being actively marketed; • The health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and • The health insurance issuer has never provided an SBC with respect to the insured product. That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after September 23, 2012, the Departments will not take any enforcement action against the plan or issuer for failing to provide an SBC before September 23, 2014 with respect to a product, provided the SBC is provided for that product no later than September 23, 2014. However, if an insured product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and			

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		the final regulations.			
Summary of Benefits and Coverage	**Q7:** The final regulations regarding the SBC included an anti-duplication provision for group health coverage clarifying that an entity required to provide an SBC would be considered to have satisfied that requirement with respect to an individual if another party provides a timely and complete SBC.[20] Is a similar anti-duplication rule applicable for student health insurance coverage?	**A7:** Yes. On March 21, 2012, HHS issued a final rule establishing requirements for student health insurance coverage.[21] The final rule defines student health insurance coverage as a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer.[22] HHS is extending the anti-duplication rule for group health coverage set forth in the final SBC regulations to student health insurance coverage, as defined in in 45 CFR 147.145(a). Therefore, the requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if another party (such as a health insurance issuer) provides a timely and complete SBC to the individual.	ACA Implementation FAQ #14	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs14.html
Annual Limit Waiver Expiration Date based on a Change to a Plan or Policy Year	**Q1:** If a group health plan or health insurance issuer that was granted a waiver from the annual limits requirements under Public Health Service Act (PHS Act) section 2711	**A1:** No. Changing the plan year (or, in the individual market, policy year) does not change the waiver expiration date. Annual limit waivers under PHS Act section 2711[1] were approved by HHS for the plan or policy year in effect when the plan or issuer applied for the waiver. The same holds true for waiver extensions. They extended the waiver	ACA Implementation FAQ #15	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

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	changes its plan year (or, in the individual market, policy year) prior to the waiver expiration date, can that change modify the expiration date of the waiver?	based on the date of the plan or policy year in effect when the initial application was submitted. As a result, waiver recipients that change their plan or policy years will not extend the expiration date of their waivers. For example, if a waiver approval letter states that a waiver is granted for an April 1, 2013 plan or policy year, the waiver will expire on March 31, 2014, regardless of whether the plan or issuer later amends its plan or policy year. That said, waiver recipients may terminate the waiver at any time prior to its approved expiration date, for example, on December 31, 2013 rather than on March 31, 2014. Additionally, HHS requested that each plan or issuer provide its effective dates of coverage as part of its annual limit waiver application, in part so that HHS would have a record of the waiver's expiration date. As noted in the Technical Instructions,[2] waiver recipients must retain all records pertaining to their waiver applications to permit HHS to conduct audits of waiver applications. If there is a discrepancy between the plan or policy year in an original application and a subsequent annual update, HHS may review the waiver to determine whether the group health plan or health insurance issuer is in compliance with HHS's policy on			

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		annual limit waivers.			
Provider Non-Discrimination	**Q2:** Will the Departments be issuing regulations addressing PHS Act section 2706(a) prior to its effective date?	**A2:** No. The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014. Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers	ACA Implementation FAQ #15	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

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		into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations. The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended. For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-*888-393*-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.			
Coverage for Individuals Participating in Approved Clinical Trials	**Q3**: Will the Departments be issuing regulations	**A3:** No. The statutory language of PHS Act section 2709 is self-implementing and the Departments do not expect to	ACA Implementation FAQ #15	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

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	addressing PHS Act section 2709 prior to its effective date?	issue regulations in the near future. PHS Act section 2709 is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after January 1, 2014. Until any further guidance is issued, group health plans and health insurance issuers are expected to implement the requirements of PHS Act section 2709 using a good faith, reasonable interpretation of the law. The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the law and will work with families and individuals to help them understand the coverage for clinical trials provision and benefit from it as intended. For questions about the coverage for clinical trials provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-*888-393*-			

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		2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.			
Transparency Reporting	**Q4:** When do plans and issuers have to comply with the transparency in coverage reporting requirements under section 1311(e)(3) of the Affordable Care Act and section 2715A of the PHS Act?	**A4:** Section 1311(e)(3) of the Affordable Care Act, as implemented at 45 CFR 155.1040(a) and 156.220, requires QHP issuers to submit specified information to the Marketplace and other entities in a timely and accurate manner. However, because QHP issuers will not have some of the data necessary for reporting under this requirement until during or after the first year of operation of their QHPs (e.g., QHP enrollment and disenrollment), HHS is clarifying that, in order to comply with section 1311(e)(3) as implemented at 45 CFR 155.1040(a) and 156.220, QHP issuers will begin submitting information only after QHPs have been certified as QHPs for one benefit year.[8] Similarly, because section 2715A of the PHS Act simply extends the transparency provisions set forth in section 1311(e)(3) of the Affordable Care Act to group health plans and health insurance issuers offering group and individual health insurance coverage, the Departments clarify that the reporting requirements under section 2715A of the PHS Act will become applicable to group health plans and	ACA Implementation FAQ #15	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html

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		health insurance issuers offering group and individual health insurance coverage no sooner than when the reporting requirements under section 1311(e)(3) of the Affordable Care Act become applicable. As previously stated, the Departments will coordinate regulatory guidance on the transparency in coverage standards for coverage offered inside and outside of the Marketplaces.[9]			
CAP Limited Competition Funding Opportunity Announcement	**Q1:** Why are only grantees that were awarded funds for this program in 2010 eligible to apply for this funding?	**A1:** The funds available through this announcement are unspent 2010 funds, which can only be shared among the States that applied for the 2010 grants. Because the amount of grant funds available is relatively small, this approach ensures that the funds are used most efficiently by leveraging the progress made by existing grantees. These grant funds will be used to extend or enhance activities being funded under the 2010 grants.	FAQ April 20, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/ltdfaq.html
CAP Limited Competition Funding Opportunity Announcement	**Q2:** The amount of funds available for this award is smaller than what was available in 2010. Why are we required to fulfill all of the same duties?	**A2:** These grants are intended to help grantees continue the type of activities started under the original 2010 Consumer Assistance Program grants. As such, funding is an extension of the grants and must be used under the terms of the original grant.	FAQ April 20, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/ltdfaq.html
CAP Limited Competition	**Q3:** What is the	**A3:** The grant period of performance is	FAQ April 20,	CCIIO	http://www.cms.gov/CCIIO/Programs-

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Funding Opportunity Announcement	grant period of performance for this award?	12 months.	2012		and-Initiatives/Consumer-Support-and-Information/ltdfaq.html
CAP Limited Competition Funding Opportunity Announcement	**Q4:** Can I request funds under this announcement to perform activities I am currently performing under the 2010 Consumer Assistance Program award funds?	**A4:** Yes. These grant funds will be used to extend or enhance activities being funded under the 2010 grants. For example, if a Consumer Assistance Program was performing an outreach campaign that included a 6-month public service announcement (PSA) on the radio under the 2010 grant award, that Consumer Assistance Program could extend the PSA beyond the original six months, or add a different PSA. The Consumer Assistance Program could also use these funds to add to the radio campaign through other media not currently included in their project plans, such as newspapers, local magazines, or television. Funds awarded under this grant funding opportunity announcement cannot be supplanted activities funded under the original grant or by any future Consumer Assistance Program funding opportunities if grant periods were to overlap.	FAQ April 20, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/ltdfaq.html
CAP Limited Competition Funding Opportunity Announcement	**Q5:** How long is the budget period for this award? Can I apply for this opportunity if my program is currently operating under the 2010	**A5:** The budget period is 12 months. 2010 Consumer Assistance Program grantees are encouraged to apply for this grant opportunity regardless of their status as a currently operating program. Applicants must be in good standing to qualify for an award, which includes	FAQ April 20, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/ltdfaq.html

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	Consumer Assistance Program grant in a No-Cost Extension period?	being up to date on all quarterly Federal Financial Reports at the time of submission of this application through the award date of this grant. Project plans for this grant opportunity must expand upon work currently in progress through any Consumer Assistance Program No-Cost Extension period, but can also provide new funding for projects or activities that may have ended under previous grant periods.			
Frequently Asked Questions about the CAP Grant Opportunity	**Q1:** What is the grant period of performance for this award?	**A1**: The grant period of performance is 12 months, from August 23, 2012 – August 22, 2013.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q2:** Can I request funds under this announcement to perform activities I am currently performing under the 2010 Consumer Assistance Program award funds or under the 2012 Consumer Assistance Program Limited Competition award funds?	**A2:** Yes. For prior award recipients, these grant funds can be used to extend or enhance activities being funded under the 2010 grants and/or the 2012 Limited Competition grants as well as funding new activities. For example, if a Consumer Assistance Program was performing an outreach campaign that included a 6-month public service announcement (PSA) on the radio under the 2010 grant award, that Consumer Assistance Program could extend the PSA beyond the original six months, or add a different PSA. The Consumer Assistance Program could also use these funds to add to the radio campaign through other media not currently included in their project plans, such as	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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		newspapers, local magazines, or television. Funds awarded under this grant funding opportunity announcement cannot supplant activities funded under the prior grant(s) or by any future Consumer Assistance Program funding opportunities if grant periods were to overlap.			
Frequently Asked Questions about the CAP Grant Opportunity	**Q3:** How long is the budget period for this award? Can I apply for this opportunity if my program is currently operating under the 2010 Consumer Assistance Program grant in a No-Cost Extension period?	**A3:** The budget period is 12 months. 2010 Consumer Assistance Program grantees may apply for this grant opportunity regardless of their status as a currently operating program. Applicants must be in good standing to qualify for an award, which includes being up to date on all quarterly Federal Financial Reports at the time of submission of this application through the award date of this grant. Project plans for this grant opportunity must expand upon work currently in progress through any Consumer Assistant Program No-Cost Extension period, but can also provide new funding for projects or activities, including those that may have ended under previous grant periods.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q4:** Will there be future funding for this grant program?	**A4:** The program was authorized for FY 2011 and beyond by the Affordable Care Act. Additional grants may be announced at some point in the future depending on availability of funding.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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Frequently Asked Questions about the CAP Grant Opportunity	**Q5:** What is the scope of work required involving Medicare, Medicaid, and CHIP?	**A5:** A program that receives funding from a Consumer Assistance Program grant is expected to refer consumers, when appropriate, to other entities that can help them better understand the Medicare, Medicaid, and CHIP programs in the State. Programs do not need to be capable of providing direct assistance to consumers on issues and problems related to Medicare, Medicaid, and CHIP. However, programs must be capable of making appropriate referrals for such consumers. Consumer Assistance Programs will be required to provide to HHS information on the number of referrals made to these programs.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q6:** Are grantees expected to help consumers enroll in self-insured group health plans?	**A6:** Yes. Section 2793(c)(1), (3) and (4) describe duties to consumers with respect to group health plans and health insurance issuers. Section 2793(c)(2) is even broader, requiring consumer assistance programs to collect data about problems encountered "by consumers."	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q7:** Are grantees required to file an appeal, internal and/or external, on behalf of consumers?	**A7:** Yes. As a requirement for receiving Consumer Assistance Program grant funds, grantees will act on behalf of, or as the designated agent for, the consumer throughout the appeals process with respect to group health	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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		plans and health insurance coverage unless prohibited from doing so under State law. In this instance, the grantee must devise an alternative plan to ensure that consumers receive that service (i.e., grantee may contract out this specific activity to a non-profit entity).			
Frequently Asked Questions about the CAP Grant Opportunity	**Q8:** How long will the grantees have to provide Consumer Assistance Program progress reports to HHS?	**A8:** Grantees have to provide progress reports to HHS during the budget period. The budget period under this grant is 12 months. The initial progress report for services provided under this grant award will be due on February 15, 2013. Quarterly reports under this grant award are due thereafter. Additionally, an annual report will be due on November 15, 2013.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q9:** Is SF-LLL a required form?	**A9:** Yes. Grant funds cannot be used for lobbying activities. This form is placed under the mandatory section in Grants.gov. Please complete the form by indicating "N/A" before uploading onto Grants.gov. If the form is not completed, regardless of the lobbying activities, Grants.gov will not allow you to submit your application.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q10:** Why does the project abstract summary require that we input a number for the federal share	**A10:** The applicant must submit a 12-month budget proposal. The grant period of performance is 12 months in duration, which happens to cross Fiscal Years. Funds may be used through the	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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	requested for five (5) years?	end of the grant period of performance to support grant activities under the grant project. Since the grant period of performance for this award is for 12 months, the applicant should enter $0 for the other years in the application.			
Frequently Asked Questions about the CAP Grant Opportunity	**Q11:** What does the prohibition on using funds for direct health care services mean? Can programs use the money to pay for their counseling staff or are you considering the counseling a direct health care service?	**A11:** Assisting consumers in reviewing their health insurance options is clearly a permitted use of grant funds. However, if counseling staff is providing health care services to the consumers, then that would be interpreted as a "direct health care service" to the individual and it would be considered a prohibited use of grant funds. Examples of direct health care services include administration of medication, outpatient visits, and specialty visits with a provider.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q12:** On page 30 of the FOA, language is included that requires meaningful input from consumers into the planning, implementation, and evaluation of the project, and that all grant budgets must include some funding to facilitate participation on the	**A12:** This requirement is meant to be satisfied by the program after it receives funding from HHS. Examples where a program could obtain consumer input may be in the form of consumer satisfaction surveys, brown-bag meetings with consumer groups, or by establishing a consumer advisory committee, just to name a few. In obtaining consumer input, programs must take the necessary steps to ensure that the modes of communication used accommodate the needs of and facilitate	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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	part of individuals who have a disability or long-term illness and their families. What does this requirement mean?	the participation of consumers with disabilities.			
Frequently Asked Questions about the CAP Grant Opportunity	**Q13:** There is no option for the work plan and timeline in the list of "mandatory documents" on the cover page of the grant application package. How do we submit the work plan and timeline?	**A13:** The applicant can attach the work plan and timeline to the "Other Attachment File."	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q14:** Are States required to continue financial support of the program in the event that federal grant funding stops?	**A14:** No.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q15:** Will training be provided during this grant cycle on how grantees can help consumers resolve problems with obtaining premium tax credits?	**A15:** No. Since individuals will not be able to receive an eligibility determination for advance payment of the premium tax credit for coverage through an Exchange until the Exchange initial open enrollment period begins in October 2013, grantees will not be required to satisfy this statutory duty during this grant's 12-month period of performance. Should a grantee extend their period of performance beyond the	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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		12 months, CMS plans to provide additional training and information on appropriate parameters of providing assistance in obtaining premium tax credits, including information on ensuring the protection of a consumer's personally identifiable information.			
Frequently Asked Questions about the CAP Grant Opportunity	**Q16:** What database software will HHS provide to grantees?	**A16:** HHS has developed a database that is available to all CAP grantees free of charge. This database collects all required CAP consumer data.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q17:** Are grantees required to use the database software that HHS has developed?	**A17:** Use of the HHS Consumer Assistance Program – Case Worker Tool is discretionary. Grantees may use alternative systems to collect and report on required data elements. The database provided by HHS allows grantees to collect and track consumer data.	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html
Frequently Asked Questions about the CAP Grant Opportunity	**Q18:** Can community-based organizations apply?	**A18:** No. Only States are eligible to apply. For the purposes of this funding opportunity, "State" means each of the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. States may contract with or enter into an agreement with one or more non-profit community-based organizations (working as a consortium) that otherwise meet the requirements of the grant to perform some or all of the grant activities under this funding	FAQ June 7, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/faq.html

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		opportunity.			
PCIP State Contracts and Extension	**Q1:** What change did CMS make to the state-based PCIP program and contracts?	**A1:** CMS has proposed a revised contract to the state-based PCIPs for the next contracting period of June through December 2013. In this revised contract, CMS proposes that state-based PCIPs work within a fixed contract amount for the remaining seven months of the program. Prior to this point, state PCIPs could seek additional funding, beyond a contract amount, if they had cost overruns. With seven months remaining in a program with a fixed appropriation, this new contract amount will give state PCIPs and CMS certainty about the funding available to administer their programs until people enrolled in PCIP can obtain coverage from a qualified health plan offered through the Health Insurance Marketplace beginning on January 1, 2014. State PCIPs will have authority to make changes necessary to remain within the funding ceiling.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html
PCIP State Contracts and Extension	**Q2:** Can a state PCIP continue its program?	**A2**: Yes. States can continue to administer PCIP. In fact, the contract that CMS has proposed to the states gives them more flexibility to operate their program within the fixed amount of the contract. Under this new contract, state PCIPs would have far more authority to make program	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html

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		changes, without seeking approval from CMS, as long as the changes remain consistent with the statutory authority, implementing regulations, and certificates of coverage under the state programs.			
PCIP State Contracts and Extension	**Q3:** Is CMS dictating a specific funding amount to the state-based PCIPs?	**A3:** CMS has requested that state PCIPs propose a contract amount that would reasonably approximate their claims liability during these last seven months of the program. CMS will work with states to negotiate an amount within the remaining funding available to the PCIP program.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html
PCIP State Contracts and Extension	**Q4:** Why is CMS making this contract change now?	**A4:** While CMS has made adjustments to premiums and benefits in the Federally-operated PCIP, it cannot do the same to the programs administered by state PCIPs. Since CMS must operate the PCIP program within the fixed $5 billion PCIP program appropriation, CMS is converting these state PCIP contracts to ensure that program costs stay within the program's appropriation.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html
PCIP State Contracts and Extension	**Q5:** Must state PCIPs accept this contract change?	**Q5:** No. A state PCIP may notify CMS that it will not enter into the new modified contract. In that case, the enrollees will be transferred into Federally-operated PCIP. We have extended the deadline for state PCIPs to decide until Friday, May 10, 2013.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html
PCIP State Contracts and	**Q6:** Will state PCIP	**Q6:** No. If a state PCIP does not agree	FAQ May 8,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Extension	enrollees lose coverage?	to the contract, CMS will transition the state's enrollees into the Federally-operated PCIP. Enrollees will not experience any break in their health coverage and will simply be covered by the Federally-operated PCIP through December 2013.	2013		act-Sheets-and-FAQs/PCIP-State-Contracts-and-Extension.html
Cost to States	**Q1:** What funding is available to assist States in the establishment of an Exchange under a fully State-based Exchange, a Partnership Exchange, and a Federally-facilitated Exchange?	**A1:** The Affordable Care Act provides funding for States establishing an Exchange through grants described in section 1311. Such grants are available for establishing a State-based Exchange, to build functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange. Grants may be awarded through the end of 2014, and grant funds are available for approved and permissible establishment activities. The process of "establishing" an Exchange may extend beyond the first date of operation and may include improvements and enhancements to key functions over a limited period of time. Generally, grants can be used to establish Exchange functions and operating systems and to test and improve systems and processes. We have determined that a State that does not have a fully certified State-based Exchange on January 1, 2013 can continue to qualify for and receive a grant award, subject to the Funding	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		Opportunity Announcement (FOA) eligibility criteria. A State can also use grant funds to build and test interfaces with HHS to support certain functions of a Federally-facilitated Exchange, such as information needed for certification of qualified health plans. As such, HHS anticipates modifying and extending the schedule for States to apply for establishments grants in future guidance to accommodate this schedule.			
Cost to States	**Q2:** What costs are States expected to assume in establishing an Exchange, and can these costs be covered by grant funding?	**A2:** Under the Affordable Care Act, States must ensure that their Exchanges are self-sustaining by January 1, 2015. Therefore, the costs to States for implementing a State-based Exchange and testing Exchange operations during 2014 may be allowed under section 1311(a). Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities after that date. Therefore, it is also permissible that under a Partnership Exchange, a State may receive a grant for activities to establish and test functions that the State performs in support of a Federally-facilitated Exchange.	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf
Cost to States	**Q3:** Will States be charged for administrative expenses when a Federally-facilitated Exchange makes a	**A3:** State Medicaid and CHIP programs will not be required to contribute to the costs associated with the Federally-facilitated Exchange, including the costs associated with a Federally-facilitated Exchange making a Medicaid or CHIP	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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	Medicaid eligibility determination?	determination. However, State Medicaid and CHIP programs will have to transfer information and cases to, and accept information and cases from, the Federally-facilitated Exchange; the costs of establishing, testing and maintaining those interfaces will be shared between the State Medicaid and CHIP programs and the Federally-facilitated Exchange, consistent with current cost allocation rules. HHS has provided additional help to States to build and maintain a shared eligibility service that allows for the Exchange, the Medicaid agency, and the CHIP agency to share common components, technologies and processes to evaluate applications for insurance affordability programs. This includes enhanced funding under Medicaid and opportunities for other State programs to reuse the information technology (IT) infrastructure without having to contribute funding for development costs related to shared services. This additional help is available to defray State costs related to establishing an efficient and effective shared eligibility service regardless of whether a Federally-facilitated Exchange or a State-based Exchange is operating in a State.			
Use of Data Services Hub	**Q4:** Will CMS charge States for use of the data services	**A4:** CMS is establishing a Federally-managed data services hub to support information exchanges between States	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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	hub?	(Exchanges, Medicaid and CHIP agencies) and relevant Federal agencies. In many cases, Federal agencies other than CMS will be providing information through the hub. Additional information about the services available through the hub and the terms for accessing those services is under development. While the agency is considering the treatment of charges for fiscal year 2014, we do not anticipate charging fully State-based Exchanges for the use of the hub.			
Basic Health Program Funding	**Q5:** Under what circumstances may Exchange planning grant dollars or the Exchange establishment grant dollars be used by a State exploring or establishing a Basic Health Program under section 1331 of the Affordable Care Act?	**A5**: *Planning grants:* Planning grant funds may be used to support research and explore health insurance coverage options permitted under the Affordable Care Act, including the option of a Basic Health Program. *Establishment grants:* Establishment grant funds may be used for Exchange establishment activities that would coordinate or overlap with activities undertaken pursuant to the establishment of an optional Basic Health Program. For example, a call center may provide consumer information on a range of coverage options including the Basic Health Program, and could therefore be funded through Establishment grant funds. However, funding under the Establishment grants cannot be used to support operations of the Basic Health Program or to investigate the feasibility of the Basic Health Program. *Other funding sources:* States electing	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		to establish a Basic Health Program may opt to fund administrative or establishment activities for the Basic Health Program through user fees or other State funding.			
Federally-facilitated Exchange and State Department of Insurance Responsibilities	**Q6:** How will the Federally-facilitated Exchange coordinate with State insurance departments?	**A6:** A Federally-facilitated Exchange will operate in States electing not to pursue a State-based Exchange. To the greatest extent possible, HHS intends to work with States to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange. Additionally, HHS will seek to harmonize Exchange policy with existing State programs and laws wherever possible. For example, qualified health plans (QHP) that will be offered in the Federally-facilitated Exchange must meet State licensure and solvency requirements and be in good standing in the State (section 1301(a)(1)(C) of the Affordable Care Act). Accordingly, States continue to maintain an important responsibility with respect to health plans licensed and offered in their State, regardless of whether the Exchange is Federally-facilitated or fully State-based. With respect to review of network adequacy, which is commonly a responsibility of State insurance departments or State health agencies in consultation with State insurance	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		departments, HHS would rely on the State for advice and recommendations regarding network adequacy standards where HHS is operating a Federally-facilitated Exchange. Network adequacy standards must ensure enrollees a sufficient choice of providers, consistent with HHS regulations. We expect that if a State has not adopted such a standard, HHS would develop it for the purposes of the Federally-facilitated Exchange using a commonly recognized and accepted standard such as the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act. Similarly, HHS is also currently working to determine the extent to which activities like the review of rates and benefit packages are already conducted by State insurance departments and how these responsibilities could be recognized as part of the certification of QHPs by a Federally-facilitated Exchange. For example, most States currently have an effective rate review program in place and HHS will rely on such processes to the extent practicable and where legally permissible. In States with a Federally-facilitated Exchange, HHS will also apply existing State standards on marketing materials, assuming issuers will be required to convey information about premiums, benefits and cost sharing that flow from			

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		data used for plan approval, and HHS will work with States to harmonize procedures for responding to consumer complaints. We recognize that most State insurance departments already have procedures in place for addressing consumer complaints, and we will work with States to utilize existing processes for consumer complaints as efficiently as possible to the extent practicable. Pursuant to our goal to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange, we are planning to establish one or more working groups with representatives from State insurance departments to start working through issues related to plan management functions in the coming weeks. Successful operation of the Federally-facilitated Exchange will depend on successfully harmonizing State and HHS workflows so that the annual QHP certification process can be effectively completed in time to adequately support open enrollment including preparation and release of an insurance web portal. We look forward to conversations with and suggestions from States in pursuit of this harmonization.			
Eligibility under a Federally-facilitated Exchange or a State-based Exchange	**Q7:** The Affordable Care Act prescribes a seamless, streamlined	**A7:** Section 155.305 of the proposed rule on Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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	eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in a qualified health plan (QHP) through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, if applicable. • Under a Federally-facilitated Exchange, can a State retain authority over Medicaid eligibility determinations? • Under a State-based Exchange, can the	Employers (Exchange Eligibility NPRM available here) proposes that the Exchange will make eligibility determinations for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, where applicable, based on modified adjusted gross income (MAGI). The Exchange Eligibility NPRM does not distinguish between a State-based Exchange and a Federally-facilitated Exchange in this regard. Based on comments to the Exchange Eligibility NPRM, however, we intend to modify this original proposal in the final rule to permit additional options for determining eligibility under a State-based and Federally-facilitated Exchange.			

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	Federal government perform activities related to advance payments of the premium tax credit and cost-sharing reductions, including the verification of employer-sponsored minimum essential coverage? Can the Federal government perform the eligibility process for exemptions from the individual responsibilit y requirement for State-based Exchanges?				

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IRS elements to which States will have access	**Q8:** What data will IRS provide to support the eligibility verification process?	**A8:** Section 6103(l)(21) of the Internal Revenue Code, as added by section 1414(a)(1) of the Affordable Care Act, permits the Secretary of the Treasury to disclose the following taxpayer information – with taxpayer consent – to support eligibility determinations for insurance affordability programs: "(i) taxpayer identity information with respect to such taxpayer, (ii) the filing status of such taxpayer, (iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse), (iv) the modified adjusted gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year, (v) such other information as prescribed by the Secretary by regulation to indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and (vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available." The IRS will provide modified adjusted gross income (MAGI) for the parents or other head of household and for certain dependents who had enough income to have been required to file a tax return. Modified	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		adjusted gross income is the adjusted gross income shown on the Form 1040 with additional amounts added: any tax-exempt interest on State or local bonds, social security benefits that are excluded from gross income, and any amounts earned abroad that are otherwise excluded from adjusted gross income. This information will be taken from the return that was last due to be filed. For example, during open enrollment in the last quarter of 2013, income information will be provided from 2012 income tax returns. The IRS will also provide information about the size of the household shown on the returns that were filed and coding to help the Exchange understand the information being provided and instances in which information may not be available. Where there has been a change in circumstance, the applicant will work with the Exchange to establish what changes should be reflected in household income. Similarly, where there is no prior year tax return data on file, for example in the case of individuals with very low or no income who had not previously been required to file, the applicant will work with the Exchange to establish household income through alternate means.			
Multi-State Plans	**Q9:** To what extent should multi-State	**A9.** While the proposed rule on Establishment of Exchange and	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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	plans contracting with the Office of Personnel Management (OPM) adhere to State-based standards, including State insurance standards (e.g., solvency, prompt payment, market conduct) as well as Exchange-specific qualified health plan certification standards in a State (e.g., network adequacy standards)?	Qualified Health Plans deems OPM-approved multi-State plans as certified by an Exchange, we recognize States' concerns about the need to apply State insurance requirements and State-specific certification standards to multi-State plans. We also note that Section 1324 requires a level playing field in connection with certain State and Federal legal requirements for health plans. We seek to ensure that implementation of section 1324 does not disrupt existing markets both inside and outside the Exchanges in the States. HHS and OPM will work with the National Association of Insurance Commissioners to address these questions. We will explore this issue by further identifying existing State standards as well as specific issues of greatest concern for multi-State plans and States including reduction of adverse risk selection, the risks to multi-State plans and States, and potential alternatives.			
Risk Adjustment Data Collection	**Q10:** Could HHS collect encounter data and let States perform risk adjustment?	**A10:** The Affordable Care Act calls for a risk adjustment program to reduce incentives for health insurance plans to avoid covering people with pre-existing conditions or those in poor health. Risk adjustment ensures that health insurance plans have a financial incentive to provide services to the people who need them most by adjusting premiums to provide more funds to plans enrolling a	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		higher proportion of people with high health costs. This mechanism ensures that insurance plans compete on the basis of quality and service, and not on the basis of avoiding sick, high-cost people. HHS issued a proposed rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (published on July 15, 2011). HHS did not propose and will not implement any proposal that calls for States or the Federal government to collect personal data such as name, social security number or address for the risk adjustment program. Protecting the privacy and confidentiality of an individual's personal health information continues to be among HHS's highest priorities. HHS will not require States to collect medical record or information that identifies an individual's doctor; nor would the Federal government collect this information.			
Quality Certification Requirements	**Q11:** What quality activities must States engage in to meet Exchange approval and certification requirements?	**A11:** The Exchange establishment grant funding opportunity announcement indicates that State-based Exchanges must develop and report a quality rating for QHPs; however, the current expectation is that further guidance will be released before Exchanges are required to implement the quality rating system. At this time, States should focus on developing and establishing other Exchange operational capacities. When	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		focusing on quality, States should consider their strategy for using quality information to certify QHPs, including when to require issuer accreditation and how to assess the quality of plans seeking to participate in Exchanges. States will also need to determine what quality information or metrics the Exchange will display to consumers and build capacity in the development of Exchange systems to accept this quality data and report it on the website. States should also consider how the Exchange will monitor QHP quality during the plan year, including performance monitoring of complaints, appeals and network adequacy. HHS intends to propose a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, transitioning to a QHP-specific rating in 2016.			
Advance Payments of the Premium Tax Credit in the Federally-facilitated Exchange	**Q12:** Will individuals who are enrolled in coverage through a Federally-facilitated Exchange have access to premium tax credits, as well as the advance payments of tax credits that will be authorized by	**A12:** Yes. The proposed regulations issued by the Treasury Department, and the related proposed regulations issued by the Department of Health and Human Services, are clear on this point and supported by the statute. Individuals enrolled in coverage through either a State-based Exchange or a Federally-facilitated Exchange may be eligible for tax credits, including advance payments. Additionally, neither the Congressional	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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	Exchanges?	Budget Office score nor the Joint Committee on Taxation technical explanation discussed limiting the credit to those enrolled through a State-based Exchange.			
Program Integrity	**Q13:** How will HHS ensure that States that adopt procedures, consistent with Federal policy and rulemaking, to streamline Medicaid and CHIP eligibility and perform real-time determinations, will not be penalized as a result of subsequent audits or error-reduction programs?	**A13:** In 2010, CMS issued new regulations establishing the principle that in applying the Payment Error Rate Measurement (PERM) program to Medicaid and CHIP, PERM reviews should measure the extent to which State policies and procedures are consistent with Federal policy and regulations. As long as Federally-approved State procedures are followed, PERM classifies the case as an accurate determination. For example, where States rely on self-attestation to establish certain facts regarding eligibility, PERM audits also rely on those self-attestations to establish those facts. If Federally-approved State policies require additional verifications and data collection, auditors will review cases against those standards. We will review and analyze all of our error rate measurement programs to ensure consistent application of this principle. While we are still evaluating how we will apply the Improper Payments Elimination and Recovery Act in the case of eligibility determinations involving advance payments of the premium tax credit, our intention is to follow the same general	FAQ November 29, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchange_q_and_a.pdf

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		principle.			
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q1:** My State is pursuing a State-based Exchange or a State Partnership Exchange for plan year 2014 (beginning on October 1, 2013). What do we need to do now?	**A1:** A State that intends to pursue a State-based Exchange or a State Partnership for 2014 should prepare to submit an Exchange Blueprint, which is comprised of two parts: ■ An Exchange Model Declaration Letter from your Governor; and ■ An Application describing readiness to perform Exchange activities and functions. The Exchange Blueprint is due no later than 30 business days prior to January 1 (i.e., on or before November 16, 2012, for plan year 2014). The Exchange Model Declaration may be submitted with the Application or before submission of the Application. If a State's model Declaration Letter is received at least 20 business days prior to the Application, a State may request a Blueprint consultation where CMS will provide technical assistance and guidance to the State in completing the Application. Note: Please see revisions to this answer below under "Blueprint Submission Deadline."	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q2:** My State is considering a Federally-facilitated Exchange. Is there anything we need to do?	**A2**: A Blueprint Application is not required. However, it is recommended that your Governor submit an Exchange Model Declaration Letter as described in the Exchange Blueprint. This will improve service to your residents by helping to ensure alignment between your existing State markets and the Federally-facilitated Exchange.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q3**: What happens if my State does not submit a Declaration Letter to HHS about its decision to pursue an Exchange Model?	**A3**: If a State does not choose an Exchange model, HHS will assume that the State is not planning to operate as a State-based Exchange or a State Partnership Exchange. HHS will operate the Federally-facilitated Exchange in the State and will perform the Exchange-related programs of risk adjustment and reinsurance. Your State will work with the Center for Medicaid and CHIP Services within CMS to determine whether the Federally-facilitated Exchange will make eligibility determinations or assessments for these programs.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q4:** Are there any advantages for a State if it submits a Declaration Letter prior to the submission of its Exchange Blueprint?	**A4:** Yes. A State pursuing a State-based Exchange or a State Partnership Exchange will be offered an opportunity to consult with CMS staff to discuss the Application portion of the Blueprint ("Blueprint Consultation") when its Model Declaration Letter is received,	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		provided the letter is received at least 20 business days prior to the submission of the application. A Blueprint Consultation is optional; it provides a State with the opportunity to ask questions and receive feedback on the preparation of the remainder of its Exchange Blueprint, prior to submission.			
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q5:** Where can I find the Blueprint? Must the application be filed electronically?	**A5:** The Blueprint Declaration Letter must be submitted through an email to State.Exchange.Group@cms.hhs.gov, as well as mailed to CMS Center for Consumer Information and Insurance Oversight (CCIIO), 200 Independence Ave SW, Suite 739H, Washington, DC 20201. The Blueprint Application must be submitted electronically, and will be available on the State Exchange Resource and Virtual Information System (SERVIS), available at: https://servis.cms.gov - Opens in a new window on September 14, 2012. The individual(s) designated by the Governor in the Model Declaration Letter may complete and electronically sign the application.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q6:** When will approval of the Exchanges be granted by HHS?	**A6:** The Affordable Care Act directs HHS to make initial Exchange approval determinations no later than January 1, 2013, for Exchange operation in plan year 2014. However, States that submit	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		their Blueprints early may receive an earlier determination. States seeking HHS approval to operate an Exchange for coverage years beginning after 2014 (e.g., plan year 2015 beginning on October 1, 2014), will submit a Model Declaration Letter and Blueprint in accordance with the same process and timeframes specified for States seeking to operate an Exchange, beginning January 1, 2014.			
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q7:** What information is required for the Blueprint?	**A7:** States are asked to submit a compilation of attestations, descriptions of processes, supporting documentation and reference files. The State may be asked to provide additional information after the Blueprint has been submitted, as determined necessary by CMS. In addition to completing the Exchange Blueprint, HHS may conduct on-site or virtual Exchange assessments, as part of its verification of an Exchange's operational readiness. HHS will use the results from a State's Reference File submissions to determine the timing for a State's operational readiness assessment. HHS will make an approval or conditional approval decision based on the documentation and the completed Exchange Blueprint. Additionally, the Establishment Review process has been designed to support States as they work toward Exchange approval. States may submit	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		documentation from HHS that confirms successful Establishment Review performance, in place of certain Blueprint required documentation.			
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q8:** What are reference files?	**A8:** These are files and documentation that the State will submit to demonstrate its Exchange's ability to perform a particular Exchange activity. Where noted, the State may attest to having received confirmation from HHS of successfully providing the relevant documentation as part of the Establishment Review. In such cases, the State does not need to upload the files, and HHS will confirm the State's submitted files and documentation from the Establishment Review conducted during oversight of the § 1311(a) grants to ensure adequate compliance related to the activity. The following provides a description of the types of reference files that may be required: a.)Summary of results of State-developed testing: These summaries document comprehensive State-defined and executed system testing, including details of Exchange activities tested, the scope of testing activities conducted, and metrics detailing the results of that testing as they relate to each designated Exchange Blueprint requirement. b.) Results of State execution of CMS-developed test scenarios: These scenarios will be developed by CMS to	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		confirm implementation of those Exchange activities that require standardization across all State Exchanges. These scenarios will be released to a central Test Library on the Collaborative Application Lifecycle Tool (CALT). c.)Summary of Independent Verification & Validation (IV&V) of applicable system components: These reports by an independent third party provide verification and validation that designated Exchange activities are built and operating as designed and in compliance with documented requirements.			
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q10:** What standard will be used for approval of a State-based Exchange?	**A10**: HHS will approve a State-based Exchange if the Blueprint and any additional operational readiness testing demonstrate that the State-based Exchange has the ability to perform Exchange activities. HHS recognizes that States will be in various stages of the Exchange development lifecycle and that some systems-development and contracting activities associated with building an operational Exchange will need to occur in 2013. Therefore, HHS will consider approving a State-based Exchange with conditions to operate for plan year 2014.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of	**Q11:** If my State	**A11:** HHS may Conditionally Approve	FAQ November	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Affordable State-based and State Partnership Insurance Exchanges	cannot demonstrate that it meets all Exchange activity requirements, what will happen?	an Exchange if the State can demonstrate that significant progress is being made on Exchange activities (listed in the Blueprint) at a pace that ensures that the State will have an operational Exchange by the initial open enrollment period (October 1, 2013).	9, 2012		act-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q12:** What does a State need to do if it receives a conditional approval of its Exchange?	**A12:** A State that receives a Conditional Approval of its Exchange will be expected to sign an agreement that outlines the terms and conditions of its Conditional Approval determination. The agreement will include provision(s) that the Exchange adhere to monitoring reviews by HHS to ensure that the establishment of the Exchange continues to progress at a pace that will allow it to be operational for the initial open enrollment period. The frequency and focus of the monitoring reviews will depend upon the Exchange activities that remain outstanding. Technical assistance and systems testing will also provided in all States that receive Conditional Approval. In addition, HHS will approve a State to operate its Exchange once it has successfully completed an Operational Readiness assessment.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership	**Q13:** How long can a State stay conditionally	**A13:** A State Exchange will remain Conditionally Approved until it meets all Approval requirements.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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Insurance Exchanges	approved?				
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q14:** Can a State reference documents in its Blueprint that were submitted to CMS during the State's Establishment Review?	**A14:** Yes. States that have received: notification from CMS of their successful completion of portions of the Establishment Review may be able to reference the information as responses to certain sections of the Blueprint.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges	**Q15:** If a State has questions about the Exchange Blueprint, who is the appropriate contact person?	**A15:** The State's State Officer at the CCIIO is the point of contact for all questions related to the Exchange Blueprint submission. General questions may be directed to State.Exchange.Group@cms.hhs.gov	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blue Print Submission Deadline	**Q1:** When does a state have to tell the Centers for Medicare & Medicaid Services (CMS) that it wants to establish a State-based Exchange for 2014?	**A1:** In order for CMS to provide a state with technical resources and support necessary to meet the January 1, 2013, approval/conditional approval statutory deadline, a state that intends to establish a State-based Exchange must submit a Declaration Letter by Friday, November 16.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blue Print Submission Deadline	**Q2:** If a state wants to establish a State-based Exchange, when is the Blueprint Application due? What about the Declaration Letter?	**A2:** In order to provide states with more time to create a comprehensive Blueprint Application that is fully representative of their work, the Department of Health and Human Services (HHS) extended the deadline for State-based Exchange Blueprint Applications to Friday, December 14, 2012. Declaration Letters for State-based Exchanges remain due on Friday,	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		November 16, 2012. CMS encourages states to begin working with the Center for Consumer Information and Insurance Oversight (CCIIO) on their Blueprint Applications as early as possible in order to identify any issues early and to receive feedback on their Blueprint Applications. A state may also submit its Blueprint Application prior to the deadline.			
Blue Print Submission Deadline	**Q3: My** state is ready to declare that it intends to establish a State-based Exchange, but still needs more time to determine whether it will establish and operate Risk Adjustment and Reinsurance programs. What should my state do?	**A3:** If a state knows what Exchange Model it intends to pursue, and who is the appropriate designee to execute the Declaration Letter, CMS encourages each state to submit a Declaration Letter on or before November 16, 2012. If a state has concerns about whether its decisions will be made by mid-November 2012, please talk to your CCIIO State Officer about your options. An interested state must commit to running either program in their Blueprint Application (Sections 5.1 and 5.2) that is due December 14, 2012. Please keep in mind that only a State that has elected to operate a State-based Exchange (not a State that has elected to participate in a State Partnership Exchange) can operate a risk adjustment program, or the State-based Exchange can defer its operation to the federal government. A state may elect to establish and operate a reinsurance program regardless of the	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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		Exchange model selected.			
Blue Print Submission Deadline	**Q4:** My state is not sure it wants to establish and operate a State-based Exchange, but we want to be involved in our Exchange. What options do we have?	**A4:** CMS established the option for states to pursue a State Partnership Exchange, where a state can work with CMS and elect to operate the Plan Management functions, Consumer Assistance functions, or both within the Federally-facilitated Exchange established for your state. States have until Friday, February 15, 2013, to submit a Declaration Letter and Blueprint Application declaring what partnership role they would like to have in operating the Exchange in their states. Ultimately, CMS wants as many states involved in operating Exchange as possible and we encourage states to talk with their CCIIO State Officer to discuss the partnership options.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
Blue Print Submission Deadline	**Q5**: If a state is ready to submit its Blueprint Application, does it have to wait until December 14, 2012?	**A5:** No, a State may submit its Blueprint Application for State-based Exchanges any time before December 14, 2012, and for State-Partnership Exchanges any time before February 15, 2013.			
Blue Print Submission Deadline	**Q6:** If a state applies to establish a State-based Exchange and later decides it would rather be a State Partnership	**A6:** Yes, if a state applies to establish a State-based Exchange for plan year 2014 and later decides it is more prepared to operate as a State Partner, it can move into a State Partnership model. States should contact their	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html

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	Exchange in 2014, can it change its mind?	CCIIO State Officer as early as possible to begin the transition.			
	Q7: If a state has a State Partnership Exchange in 2014, can it move to a State-based Exchange in 2015?	**A7:** Yes. If a state decides to be a State-based Exchange for plan year 2015, it will have to submit its State-based Exchange Declaration Letter and Blueprint Application, completing all the relevant additional sections. For the 2015 plan year, the Declaration Letter and Blueprint Application are due November 18, 2013, and December 16, 2013, respectively. It can also establish a State-based Exchange in subsequent years.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-blueprint-states.html
State-Based Exchanges and State Partnership Exchanges	**Q1.** Does HHS plan to further extend deadlines for states to decide on their level of involvement in implementing Exchanges?	**A1:** No. As mentioned in the two letters that Secretary Sebelius sent to governors in November2012, states have been and will continue to be partners in implementing the health care law and we are committed to providing states with the flexibility, resources and time they need to deliver the benefits of the health care law to the American people. In response to various governors' requests for additional time, we extended the deadline for a Blueprint Application to operate a State-Based Exchange from November 16, 2012 to December 14, 2012. If a state is	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		pursuing a State Partnership Exchange, we will accept Declaration Letters and Blueprint Applications and make approval determinations for State Partnership Exchanges on a rolling basis. A state that plans to operate the Exchange in its state in partnership with the federal government starting in 2014 will need to submit its Declaration Letter and Blueprint Application declaring what partnership role they would like to have by February 15, 2013. A state may apply at any time to run an Exchange in future years.			
State-Based Exchanges and State Partnership Exchanges	**Q2.** What federal funding is available to assist a state in creating and maintaining a State-Based Exchange? Will a state have to return federal funding if it decides not to implement a State-Based Exchange?	**A1:** By law, states operating Exchanges in 2014 must ensure that their Exchanges are financially self-sustaining by January 1, 2015. The costs to states for establishing a State-Based Exchange and testing Exchange operations during 2014 may be funded by grants under section 1311(a). Additionally, grants under section 1311 may be awarded until December31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014). It is also permissible that under a State Partnership Exchange, a state may receive grants for activities to establish	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		and test functions that the state performs in support of a Federally-Facilitated Exchange. This applies whether or not a state is a State Partnership Exchange. Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards.			
State-Based Exchanges and State Partnership Exchanges	**Q3.** Will HHS charge fees to a state that utilizes federal data in connection with its State-Based Exchange?	**A3:** No. HHS is establishing a federally-managed data services hub to support information exchanges between states (Exchanges, Medicaid and CHIP agencies) and relevant federal agencies. In many cases, federal agencies other than HHS will be providing information through the hub. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
State-Based Exchanges and State Partnership Exchanges	**Q4.** What is the approval process for a state that would like to participate in a State Partnership Exchange?	**A4.** To operate a State Partnership Exchange in 2014, a state must submit a declaration letter, complete the relevant portions of the Exchange Blueprint and be approved or conditionally approved by HHS for participation in a State Partnership Exchange. State Partnership Exchange approval standards mirror State-Based Exchange approval standards for plan management and the relevant consumer activities, where applicable, and include standards related to sharing data and coordinating processes between the state and a	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		Federally-Facilitated Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange.			
Federally-Facilitated Exchange	**Q5**. How will HHS work with state policymakers to make sure that the Federally-Facilitated Exchange accounts for the needs of a particular state? How will the Federally-Facilitated Exchange for each state ensure that it accurately incorporates state-specific laws and procedures into its business processes?	**A5.** To the greatest extent possible, HHS intends to work with states to preserve the traditional responsibilities of state insurance departments when establishing a Federally-Facilitated Exchange for a particular state. Additionally, HHS will seek to harmonize Exchange policy with existing state programs and laws wherever possible. For example, qualified health plans that will be offered in a Federally-Facilitated Exchange must be offered by issuers that meet state licensure and solvency requirements and are in good standing in the state (section 1301(a)(1)(C) of the Affordable Care Act; 45 C.F.R. section 156.200(b)(4)). In addition, qualified health plans will be subject to requirements that apply to all individual and small group market products such as the proposed market rules. Accordingly, states continue to maintain an important responsibility with respect to qualified health plans licensed and offered in their states, regardless of whether the Exchange is Federally-Facilitated or State-Based. HHS is currently working to determine	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		the extent to which activities conducted by state insurance departments such as the review of rates and policy forms could be recognized as part of the certification of qualified health plans by a Federally-Facilitated Exchange. For example, most states currently have an effective rate review program in place and HHS will rely on such processes in connection with qualified health plan certification decisions and oversight by a Federally-Facilitated Exchange. HHS will work with regulators in each state with a Federally-Facilitated Exchange to identity these efficiencies. HHS is working with the National Association of Insurance Commissioners to enable states to use the System for Electronic Rate and Form Filing as part of the qualified health plan submission and certification process in a State Partnership Exchange. This will help ensure that state and federal regulators are using the same data for their reviews and simplify issuer compliance responsibilities. HHS also will collect state-specific Medicaid and CHIP policy data so that the Federally-Facilitated Exchange is able to evaluate Medicaid and CHIP eligibility.			
Federally-Facilitated	**Q6.** Will Federally-	**A6.** Yes. HHS will operate the	FAQ December	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Exchange	Facilitated Exchange customer support personnel be familiar with state rules so that they can advise consumers adequately?	Federally-Facilitated and State Partnership Exchange call center and website, and personnel will be trained on relevant state insurance laws and Medicaid and CHIP eligibility standards so that they can advise consumers. In a state operating in a State Partnership Exchange, a state will be responsible for the day-to-day management of the Exchange Navigators and the development and management of another separate in-person assistance program, and may elect to conduct additional outreach and educational activities. The Affordable Care Act directs Navigators to conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of qualified health plans and distribute information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.	10, 2012		iles/Downloads/exchanges-faqs-12-10-2012.pdf
Federally-Facilitated Exchange	**Q7.** What restrictions will there be on a state regulator's authority to enforce state laws when consumers purchase	**A7.** States have significant experience and the lead role in insurance regulation, oversight, and enforcement. We will seek to capitalize on existing state policies,	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	coverage through a Federally-Facilitated Exchange? Will states retain their ability to protect consumers?	capabilities, and infrastructure that can also assist in implementing some of the components of a Federally-Facilitated Exchange. We also encourage states interested in improving this alignment to apply to conduct plan management through a State Partnership Exchange. A Federally-Facilitated Exchange's role and authority are limited to the certification and management of participating qualified health plans. Its role and authority do not extend beyond the Exchange or affect otherwise applicable state law governing which health insurance products may be sold in the individual and small group markets. Several qualified health plans certification standards rely on reviews that some state departments of insurance may not currently conduct. Therefore, HHS will evaluate each potential qualified health plan against applicable certification standards either by deferring to the outcome of a state's review (e.g., in the case of licensure) or by performing a review necessary to verify compliance with qualified health plan certification standards. Federally-Facilitated Exchanges will consider completed state work to support this evaluation to the extent possible.			
Federally-Facilitated	***Q8.*** How will the	**A8.** To fund the operation of the	FAQ December	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Exchange	Federally-Facilitated Exchange be funded?	Federally-Facilitated Exchange, we proposed for comment in the draft Payment Notice that participating issuers pay a monthly user fee to support the operation of the Federally-Facilitated Exchange. For the 2014 benefit year, we proposed a monthly user fee rate that is aligned with rates charged by State-Based Exchanges. While we proposed that this rate be 3.5 percent of premium, it may be adjusted in the final Payment Notice to take into account State-Based Exchange rates. Exchange user fees will support activities such as the consumer outreach, information and assistance activities that health plans currently pay themselves. This policy does not affect the ability of a state to use grants described in section 1311 of the Affordable Care Act to develop functions that a state elects to operate under a State Partnership Exchange and to support state activities to build interfaces with a Federally-Facilitated Exchange.	10, 2012		iles/Downloads/exchanges-faqs-12-10-2012.pdf
Federally-Facilitated Exchange	**Q9.** If a state chooses to provide some services to a Federally-Facilitated Exchange, will the state be reimbursed for its costs?	**A9.** Yes in certain circumstances. HHS expects that states supporting the development of a Federally-Facilitated Exchange may choose to seek section 1311(a) Exchange Establishment cooperative agreement funding for activities including, but not limited to: • Developing data system interfaces with the Federally-Facilitated Exchange; •	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		Coordinating the transfer of plan information (e.g., licensure and solvency) from the state insurance department to the Federally-Facilitated Exchange; and • Other activities necessary to support (and related to the establishment of) the effective operations of a Federally-Facilitated Exchange. After section 1311(a) funds are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed on behalf of the Federally-Facilitated Exchange. To the extent permissible under applicable law, HHS intends to make tools and other resources used by the Federally-Facilitated Exchange available to state partners in State Partnership Exchanges, as well as to State-Based Exchanges.			
Market Issues	**Q10.** How are Exchanges going to increase insurance market competition based on quality and cost? Some markets may be starting off from a position of having few local issuers.	**A10.** The introduction of Exchanges and the insurance market rules in 2014 will help promote competition based on quality and cost since consumers will have an unprecedented ability to compare similar products from different issuers and will be assured the right to purchase these products, regardless of their health condition. Further, consumers in many states will have new options such as the ability to purchase coverage from the Consumer Operated and Oriented Plans and Multi-State Plans created under the Affordable Care Act. Additionally, Exchanges can	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		leverage market forces to drive further transformation in health care delivery. We anticipate that the number of individuals who will be eligible for advance payments of premium tax credits and cost-sharing reductions – which are only available in connection with qualified health plan coverage purchased through an Exchange – will attract issuers to Exchanges where the certification process will encourage and reward high quality affordable insurance offerings. In addition, HHS is developing a Star Ratings system for qualified health plans purchased in an Exchange pursuant to section 1311(c)(3) of the Affordable Care Act.			
Market Issues	**Q11.** When will we have final rules on essential health benefits, actuarial value, and rating?	**A11.** The proposed rules on essential health benefits and actuarial value and the market reforms ,including rating, were published on November 20, 2012. Public comments are due by December 26, 2012. On November 20, 2012, we also issued a state Medicaid directors letter on how we will propose essential health benefits be implemented in Medicaid. HHS will analyze the comments, adjust any policies accordingly, and publish final rules early next year.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Market Issues	**Q12.** What level of benefit is required in a specific benchmark to satisfy the ten	**A12.** In section 156.100 of the proposed rule on Essential Health Benefits/Actuarial Value/Accreditation, we propose criteria for the selection	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	essential health benefit categories? What process will be undertaken by HHS to select backfilling benefit options if a state defaults to the largest small group product?	process for a state that chooses to select a benchmark plan. The essential health benefits benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. This approach and benchmark selection, which would apply for at least the 2014 and 2015 benefit years, would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. Since some base-benchmark plan options may not cover all ten of the statutorily required essential health benefits categories, we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories. We also propose that if a base-benchmark plan option does not cover any items and services within an essential health benefits category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all ten essential health			

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		benefits categories, must meet standards for non-discrimination and balance. After meeting these standards, it would be considered the essential health benefits-benchmark plan. The proposed rule also outlines the process by which HHS would supplement a default base-benchmark plan, if necessary. We clarify that to the extent that the default base-benchmark plan option does not cover any items and services within an essential health benefits category, the category must be added by supplementing the base-benchmark plan with that particular category in its entirety from another base-benchmark plan option. Specifically, we propose that HHS would supplement the category of benefits in the default base benchmark plan with the first of the following options that offer benefits in that particular essential health benefits category: (1) the largest plan by			

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		enrollment in the second largest product in the state's small group market; (2) the largest plan by enrollment in the third largest product in the state's small group market; (3) the largest national Federal Employees Health Benefit Program plan by enrollment across states that is offered to federal employees; (4) the largest dental plan under the Federal Employees Dental and Vision Insurance Program, for pediatric oral care benefits; (5) the largest vision plan under the Federal Employees Dental and Vision Insurance Program, for pediatric vision care benefits; and (6) habilitative services as described in section 156.110(f) or 156.115(a)(4).			
Multi-State Plans	**Q13.** The Office of Personnel Management is required to certify Multi-State Plans that must be included in every Exchange. How will you ensure that Multi-State Plans compete on a level playing field and are compliant with state laws?	**A13.** The U.S. Office of Personnel Management released a proposed rule implementing the Multi-State Plan Program on November 30, 2012. To ensure that the Multi-State Plans are competing on a level playing field with other plans in the marketplace, the proposed regulation largely defers to state insurance law and the standards promulgated by HHS and states related to qualified health plans. Under the proposal, Multi-State Plans will be evaluated based largely on the same	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		criteria as other qualified health plans operating in Exchanges. The few areas in which the Office of Personnel Management proposes different regulatory standards from those applicable to qualified health plans are areas where the Office of Personnel Management has extensive experience through its administration of the Federal Employees Health Benefits Program. However, in order to ensure that these few differences will not create any unfair advantages, the Office of Personnel Management seeks comment from states and other stakeholders on these proposals. The regulation appeared in the Federal Register on December 5, 2012, and the comment period runs through January4, 2013.			
Bridge Plan	**Q14.** Can a state-based Exchange certify a Medicaid bridge plan as a qualified health plan?	**A14.** Yes. HHS has received questions about whether a state could allow an issuer that contracts with a state Medicaid agency as a Medicaid managed care organization to offer qualified health plans in the Exchange on a limited-enrollment basis to certain populations. This type of limited offering would permit the qualified health plan to serve as a “bridge” plan between	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		Medicaid/CHIP coverage and private insurance. This would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network. This approach is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange. In general, an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a qualified health plan as a Medicaid bridge plan under the following terms: • *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act.* Consistent with section 2702(c) of the Public Health Service Act, a health plan whose provider network reaches capacity may deny new enrollment generally while continuing to permit limited enrollment of certain			

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		individuals in order to fulfill obligations to existing group contract holders and enrollees. Therefore, if the issuer demonstrates that the provider network serving the Medicaid managed care organization and bridge plan has sufficient capacity only to provide adequate services to bridge plan eligible individuals and existing Medicaid and/or CHIP eligible enrollees, the bridge plan could generally be closed to other new enrollment. However, in order to permit additional enrollment to be limited to bridge plan eligible individuals, the state must ensure there is a legally binding contractual obligation in place requiring the Medicaid managed care organization issuer to provide such coverage to these individuals. We note that any such contract would need to have provisions to prevent cost-shifting from the non-Medicaid/CHIP population to the Medicaid/CHIP population. We also note that the guaranteed availability provision of section 2702 of the Public Health Service Act is an important protection that provides consumer access to the individual and small group markets. Accordingly, we plan to construe narrowly the network capacity exception to the general guaranteed issue requirement. • *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization*			

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		meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers. • As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits. • The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options. • The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits. This will be done using the same mechanism that will be in place for the larger Exchange population. Successful implementation of a Medicaid bridge plan will involve a high degree of coordination between the state Medicaid agency, department of insurance and the Exchange. States operating State-Based Exchanges will be best positioned to achieve the level of coordination needed to implement and support the offering of a Medicaid			

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		bridge plan on an Exchange. Additional guidance will be issued soon.			
Pre-Existing Condition Insurance Plan and Other High-Risk Pools	**Q15.** Does the federal government intend to maintain the Pre-Existing Condition Insurance Plan program beyond 2014? How will state high risk pools be affected by the affordability and insurance market reforms in 2014?	**A15.** Under the Affordable Care Act, coverage for persons under the Pre-Existing Condition Insurance Plan program (whether federally-run or state-run in a state) will generally not extend beyond January 1, 2014, which is when all individuals will be able to access coverage without any pre-existing condition exclusions in the individual market. The transitional reinsurance program is expected to help stabilize premiums in the individual market by reimbursing issuers who enroll high cost individuals, such as those currently enrolled in the Pre-Existing Condition Insurance Plan, as they enter that market. In the notice of proposed rulemaking on the health insurance market rules (77 Fed. Reg.70584; November 26, 2012), we noted that we are exploring ways in which states could continue to run their existing high risk pools (i.e., separate from the Pre-Existing Condition Insurance Pool program) beyond 2014.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Basic Health Plan	**Q16.** Will HHS issue federal guidance and regulation regarding implementation of the Basic Health Plan?	**A16.** Yes. HHS plans to issue guidance on the Basic Health Plan in the future. States interested in this option should continue to talk to HHS about their specific questions related to the implementation of the Basic Health Plan.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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Consumer Outreach	**Q17.** How does HHS plan to conduct outreach about the Exchanges and new coverage options? Will outreach materials be tailored to each state? Will states be able to provide HHS with input in developing materials?	**A17.** Education and outreach are high priorities for implementing the changes coming in 2014.HHS plans to conduct outreach to consumers in a variety of ways, including the Navigator program, in-person assistance, the internet, and call centers. States and other stake holders definitely will be able to provide input in developing its outreach approach to consumers.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Consumer Outreach	**Q18.** How does HHS plan to operate the Navigator program for the Federally-Facilitated Exchanges? How many and what types of Navigators will there be in a particular state? What will their roles be? Can states require Navigators to hold a producer license? If not, what type of training or certification will they receive?	**A18.** Section 1311(i) of the Affordable Care Act directs an Exchange – whether a State-Based Exchange or a Federally-Facilitated Exchange – to establish a program under which it awards grants to Navigators. Section 1311(i) and 45 C.F.R. section 155.210 articulate the required duties of a Navigator. In addition, section 155.210(c)(2) directs that the Exchange select two different types of entities as Navigators, one of which must be a community and consumer-focused non-profit group. This program is further described in the "General Guidance on Federally-facilitated Exchanges." The number of Navigators per state served by a Federally-Facilitated Exchange will be contingent upon the total amount of funding available as well as the number of applications that we receive in each state in response to the forthcoming	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		Navigator Grant Funding Opportunity Announcement that we plan to issue early next year to support the Federally-Facilitated Exchanges. Additionally, a state or Exchange cannot require Navigators to hold a producer license (i.e.,a license as an agent or broker) for the purpose of carrying out any of the duties required of Navigators in section 1311(i)(3) of the Affordable Care Act and 45 C.F.R. section 155.210(e). Because the law directs Navigators to carry out all required duties, linking a producer license to any one of those specific duties would have the effect of requiring all Navigator entities, their employees, and their sub-grantees to hold a producer license. As described above, this would prevent the application of the standard set forth in 45 C.F.R. section155.210(c)(2) that at least two different types of entities must serve as Navigators. As such, and as provided by section 1321(d) of the Affordable Care Act, any state laws which would require all Navigators to hold a producer license would be preempted by 45 C.F.R. section155.210(c)(2). In Federally-Facilitated Exchanges and State Partnership Exchanges, individuals selected to receive Navigator grants or working for entities selected to receive Navigator grants must successfully participate in an HHS-developed and			

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		administered training program, which will include a certification examination pursuant to 45 C.F.R. section 155.210(b). In addition, under state law, states may impose Navigator-specific licensing or certification requirements upon individuals and entities seeking to operate as Navigators, so long as such licenses or certifications are not preempted by the requirement to award to different types of entities identified in 45 C.F.R. section 155.210(c)(2), such as producer licenses.			
Consumer Outreach	**Q19.** What does HHS expect that states in a State Partnership Exchange must do to fulfill their obligations regarding in-person consumer assistance? How will the state-specific in-person consumer assistance programs be integrated with the Navigator program?	**A19.** In-person assistance programs are an additional mechanism through which Exchanges may meet the consumer assistance responsibilities of the Exchange under 45 C.F.R. section 155.205(d) and (e). As described in the Federally-facilitated Exchange Guidance, states operating under a State Partnership Exchange will build and operate an in-person assistance program, for which grant funding is available under section 1311 of the Affordable Care Act, distinct from the Navigator program for that Exchange. State-Based Exchanges may do so as well. The purpose of providing multiple tools for in-person assistance is to ensure that all consumers can receive help when accessing health insurance coverage through an Exchange.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Consumer Eligibility and	**Q20.** What	**A20.** Section 1413 of the Affordable	FAQ December	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Enrollment	information will consumers provide in the single streamlined application? What is the process/timeline for the approval of a state-specific single streamlined application?	Care Act directs HHS to develop a single, streamlined application that will be used to apply for coverage through qualified health plans, Medicaid and CHIP. In addition, it can be used by persons seeking the advance payment of premium tax credits and cost sharing reductions available for qualified health plans through the Exchange. In consultation with states and other stakeholders, and with the benefit of extensive consumer testing, HHS has been developing an on-line and paper version of the single, streamlined application. We are releasing information on a rolling basis both to seek public comment and to support states in their eligibility system builds. In July 2012, HHS published a notice in the Federal Register outlining the initial data elements that will be included in the streamlined application for public comment. HHS received over 60 comments from states and other stakeholders that have helped inform our ongoing development work. These comments, coupled with ongoing consumer testing, have helped us refine and improve the application. Consumer testing and extensive consultation with states and consumer groups continues. HHS expects to provide the final version of the online and paper application in early 2013and will also work with states that seek	10, 2012		iles/Downloads/exchanges-faqs-12-10-2012.pdf

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		Secretarial approval for their own application.			
Consumer Eligibility and Enrollment	***Q21.*** What will consumers be told if it appears they are not eligible for Medicaid, CHIP, or advance payments of premium tax credits?	**A21.** A qualified individual still will have the option to purchase a qualified health plan through the Exchange if he or she is not eligible for Medicaid. CHIP or an advance payment of a premium tax credit. As outlined in 45 C.F.R. section 155.310(g), Exchanges will provide timely written notice to an applicant of any eligibility determination made by the Exchange.45 C.F.R. section 155.230(a) provides further detail on the content of notices, including that notices contain contact information for available customer service resources and an explanation of appeal rights, if applicable.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Consumer Eligibility and Enrollment	**Q22.** How will HHS help Exchanges with the eligibility process for exemptions from the shared responsibility payment for individuals?	**A22.** Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will issue certificates of exemption from the shared responsibility payment described in section5000A of the Internal Revenue Code, which otherwise applies to individuals who do not maintain minimum essential coverage. In the "State Exchange Implementation Questions and Answers" released on November 29, 2011, we indicated that a State-Based Exchange could either conduct this assessment itself or use a federally-managed service for exemptions from the shared	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		responsibility payment. We included this option in the Exchange Blueprint. State-Based Exchanges can also choose to conduct this function independently. With this service, the Exchange will accept an application for an exemption, and then transfer the information contained on the application to HHS through a secure, electronic transaction. HHS will conduct relevant verifications and return an eligibility determination to the Exchange, which will then notify the individual who submitted the application. The Exchange and HHS will share responsibility for customer service. To the extent that an individual's situation changes during the year, he or she would be required to submit an update to the Exchange, which will then transfer it to HHS to process. This configuration limits the level of effort required on the part of the Exchange, while ensuring that the Exchange complies with the statutory direction to issue certificates of exemption. HHS will provide additional information regarding exemptions shortly, including technical specifications for the application and for the application transfer service.			
Consumer Experience	**Q23.** How will the Federally-Facilitated Exchange display qualified health plan options to	**A23.** Consumers will see all qualified health plans, including stand-alone dental plans, certified to be offered through the Federally-Facilitated	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	consumers? Will consumers see all of their options or just those that are "best" for them? Will the Federally-Facilitated Exchange allow individuals who are eligible for Medicaid or CHIP to purchase qualified health plans instead?	Exchange, offered in their service area. HHS is developing ways for consumers to sort qualified health plan options based on their preferences. Qualified individuals who are Medicaid or CHIP eligible are allowed to purchase qualified health plans instead of receiving coverage through the Medicaid or CHIP programs. However, they are not eligible to receive advance payments of premium tax credits or cost-sharing reductions to help with the cost of purchasing qualified health plans through an Exchange.			
Medicaid-Expansion	**Q24.** Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care	**A24.** No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions. As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	Act**?**	plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process. While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to "newly eligible individuals" are tied by law to specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.			
Medicaid-Expansion	**Q25.** If a state accepts the expansion, can a state later drop out of the expansion	**A25.** Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	program?				
Medicaid-Expansion	**Q26.** Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?	**A26.** No. Congress directed that the enhanced matching rate be used to expand coverage to133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing. In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.			
Medicaid-Expansion	**Q27.** Do you still support the Medicaid blended FMAP (matching rate) proposal in your budget?	**A27.** No. We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Medicaid-Expansion	**Q28**. How does the Supreme Court ruling affect the interaction between the Exchanges and Medicaid? Will a state's decision whether or not to	**A28.** As the letter from Secretary Sebelius to Governors sent on July 10, 2012 and the letter from the CMS Acting Administrator Marilyn Tavenner sent on July 13, 2012 stated, the Supreme Court's decision affects the financial penalty that applies to a state that does not expand Medicaid coverage	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	proceed with the Medicaid expansion have implications for the Exchange's ability to make Medicaid eligibility determinations?	to 133% of the federal poverty level under the Affordable Care Act. No other provisions of the law were affected. Thus regardless of whether a state adopts the Medicaid expansion, the provisions related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each state will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state's option) based on the Medicaid rules in the state, including the income levels at which the state's Medicaid program provides coverage.			
Medicaid-Expansion	**Q29.** What help will be available to states to accommodate the added administrative burdens and costs they will have to bear if they expand coverage in Medicaid?	**A29.** We have provided 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive state and stakeholder consultation, a new combined and streamlined application that states can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		provide States additional support for the administrative costs of eligibility changes. These and other initiatives relating to state systems development will lower administrative costs. Implementation of the on-line application system, the new data-based eligibility rules, verification and renewal procedures and states' access to the federally-managed data services hub ("the hub") will collectively help defray states' ongoing costs and result in greater efficiency in the long term. For example, states will be able to electronically verify eligibility factors through the hub, where previously they had to verify through multiple federal venues. This is expected to lower the per-person administrative costs of enrollment and renewal for both newly and currently eligible individuals. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there. In addition, it is anticipated that many individuals—both those who are eligible under current state eligibility rules as well as those who are eligible under the adult expansion—will apply for coverage via the Exchange. Our rules provide states the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain			

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		standards. No charge will be imposed on states for the Medicaid determinations or assessments conducted by the Exchanges.			
Medicaid-Expansion	**Q30.** CMS has released 90/10 funding in order for states to improve their eligibility systems for Medicaid. Will that funding continue?	**A30.** Yes. "90/10" funding remains available through December 31, 2015 for Medicaid eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements. In previous guidance, we have assured states that the 90/10 and 75/25 percent funding for eligibility systems will be available without regard to whether a state decides to expand its program to cover newly eligible low-income adults. We reiterate that system modernization will be supported and the enhanced matching funds will be available regardless of a state's decision on expansion. Additionally, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
Medicaid-Expansion	**Q31.** Will low-income residents in states that do not expand Medicaid to 133 percent of the	**A31.** Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?	other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.			
Medicaid-Expansion	**Q32.** Can states that are "expansion states" under the law receive newly eligible matching rate for some populations in their state?	**A32.** Yes. The expansion state Federal Medical Assistance Percentage, or matching rate, described in section 1905(z)(2) of the Social Security Act is available to some states that expanded Medicaid coverage prior to enactment of the Affordable Care Act, but does not exclude those states from receiving the increased newly eligible match for expenditures for beneficiaries who meet the statutory qualifications. If a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. States will receive the highest matching rate possible for a given population; being an expansion state will never disadvantage the state in terms of matching rates for that population. The following are several examples of circumstances in which an expansion state will receive the newly eligible matching rate for some beneficiaries: • States are considered expansion states if, as of March 23, 2010, they provided coverage that meets the standards specified in section	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		1905(z)(3) of the Act to both childless adults and parents up to at least 100 percent of the federal poverty level. If a state provided Medicaid coverage up to 100 percent of the federal poverty level but not above, expenditures for individuals between 100 and 133 percent of the federal poverty level would qualify for the newly eligible matching rate. • States that qualify as expansion states may have offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits. Individuals who received limited benefits under a Medicaid expansion will qualify as "newly eligible" individuals and the newly eligible matching rate will apply. • States that qualify as expansion states based on the provision of state-funded coverage will receive the newly eligible matching rate for people previously covered by the state-only program, since they will be newly eligible for Medicaid coverage. The expansion state matching rate is only available for expenditures for non-pregnant, childless adult populations described in the new low-income adult group. CMS will work with states to ensure that the correct matching rate is applied to expenditures for populations in expansion states that qualify as newly eligible.			
Flexibility for States	**Q33.** What specific plans and timeline do	**A33.** CMS continues to work closely	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-

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	you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?	with states to provide options and tools that make it easier for states to make changes in their Medicaid programs to improve care and lower costs. In the last six months, we have released guidance giving states flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a state to adopt selective contracting in the program, and developed a detailed tool to help support states interested in extending managed care arrangements to long term services and supports. We have also established six learning collaboratives with states to consider together improvements in data analytics, value-based purchasing and other topics of key concern to states and stakeholders, and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations. Information about these and many other initiatives are available on Medicaid.gov We welcome continued input and ideas from states and others. States can			2012.pdf

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		implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals. For example, states can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.			
Flexibility for States	**Q34.** Will the federal government support options for the Medicaid expansion population that encourage personal responsibility?	**A34.** Yes, depending on its design. We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		care decisions as well as accountability tied to improvement in health outcomes. We note in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level, to accomplish these objectives, including Secretary-approved benchmark coverage.			
Flexibility for States	**Q35.** Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?	**A35.** Consistent with the guidance provided above with respect to demonstrations available under the regular and the enhanced matching rates, CMS will work with states on their proposals and review them consistent with the statutory standard of furthering the interests of the program.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf
MAGI	***Q36.*** *Will states still be required to convert their income counting methodology to Modified Adjusted Gross Income (MAGI) for purposes of determining eligibility regardless of whether they expand to the adult group? If so, how do states link the categorical eligibility*	**A36.** Yes, as required by law. Conversion to modified adjusted gross income eligibility rules will apply to the nonelderly, nondisabled eligibility groups covered in each state, effective January 2014, without regard to whether a state expands coverage to the low-income adult group. The new modified adjusted gross income rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through Exchanges; the application of modified adjusted gross income to Medicaid and CHIP will	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	criteria to the MAGI?	promote a simplified, accurate, fair, and coordinated approach to enrollment for consumers. CMS has been working with states to move forward with implementation of the modified adjusted gross income rules, and consolidation and simplification of Medicaid eligibility categories.			
DSH	**Q37.** The Disproportionate Share Hospital allotments will be reduced starting in 2014 using a methodology based on the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? Is HHS planning any modification to the manner in which it will reduce DSH allotments as it relates to states that	**A37.** The law directs HHS to develop a methodology to reduce Disproportionate Share Hospital (DSH) funding over time in a way that is linked to reductions in the number of uninsured or how states target their funds. We have heard from states and health care providers about their concerns related to this change and are exploring all options. The Department will propose this methodology for public comment early next year.	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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	do not expand?				
COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS	**Q38.** How can states use premium assistance to help families that are split among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP) enroll in the same plans?	**A38.** In 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance, an option under current law, provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid/CHIP eligible families pay for available employer-based coverage that the state determines is cost effective. There are cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards. In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Exchange. Please note that advance	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		payments of the premium tax credit and cost-sharing reductions are not available for an individual who is eligible for Medicaid or CHIP. The statutory authorities that permit use of title XIX or title XXI funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are sections 1905(a)and 2105(c)(3) of the Social Security Act. For example, beginning in 2014, when a child is eligible for Medicaid/CHIP and the parent is enrolled in a qualified health plan through the Exchange, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. The premium tax credit would not be available to help cover the cost of coverage for these children. As noted above, with respect to the children, the state would adhere to federal standards for premium assistance, including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate. A State-Based Exchange may be able to support such an option, and in states where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP			

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		agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements			
COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS	**Q39**. How can states use premium assistance to promote continuity of care when individuals move between Exchange, CHIP, and Medicaid coverage?	**A39.** The Affordable Care Act envisions and directs that there be a coordinated system for making eligibility determinations between Medicaid, CHIP and the Exchange to avoid gaps in coverage as individuals' income fluctuates. Smooth eligibility transitions will not necessarily prevent people from having to select a new plan and/or provider when they lose eligibility for one insurance affordability program and gain eligibility for another. The extent to which such changes in plans and providers occur will depend on whether and to what degree plans participate in both the Exchange and in Medicaid and CHIP, and the networks in such plans. Premium assistance can help address this issue, while encouraging robust plan participation in Medicaid, CHIP, and the Exchange. As discussed above, this option permits state Medicaid or	FAQ December 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf

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		CHIP programs to use premium assistance to enroll a Medicaid or CHIP eligible individual or family in a qualified health plan through the Exchange. States may be most interested in this option for families close to the top of the Medicaid income limit. Under this arrangement, if a family's income changes such that some or all members of the family become ineligible for Medicaid or CHIP and eligible for a premium tax credit to help cover the cost of a qualified health plan through the Exchange, it would be less likely that members moving into Exchange coverage would need to change plans or providers. Similarly, premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same qualified health plan in which they had been enrolled through the Exchange. As discussed above, premium assistance options in Medicaid and CHIP are subject to federal standards related to wrap around benefits, cost sharing and cost effectiveness. There may also be an opportunity for states to promote continuity of coverage through "bridge plans" as described earlier.			
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q1:** How Do I Obtain a Waiver Extension?	**A1:** An applicant who has applied for, and has been granted, a waiver prior to June 17, 2011 for plan years (in the individual market, policy years)	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf

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		between September 23, 2010 and September 22, 2011 may apply for an extension of the existing waiver. Waiver extensions are valid until the plan or policy year beginning on or after January 1, 2014, when the restricted annual limits expire (i.e., when no annual dollar limits are permitted on any essential health benefits). An existing waiver recipient must submit a complete Waiver Extension by September 22, 2011 in order to elect the waiver extension. The process for doing so is described below. 1. Obtain a copy of the Excel spreadsheet entitled "Annual Limit Waiver – Waiver Extension" from the Annual Limit Waivers website at the following URL: http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html. a. This simplified form requests updated contact information, including the name and contact information of the applicant,2as well as the name and contact information of the person who prepared the annual update; enrollment information for the plan (or in the individual market, policy) at the time the update is sent; and the plan or policy's current overall annual limit.			

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		b. When filling out this application, existing waiver recipients must use the same applicant name that was published in CCIIO's public waiver list, which can be found via the following URL (list is broken out by type of applicant, i.e., Self- Insured Employer, Issuer, etc.): http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html. 2. In a separate document, the applicant should also provide the language from the attestation in section V of these Technical Instructions, using the "Waiver Extension" language. The attestation certifies: a. Your plan or policy was in existence prior to September 23, 2010; b. Compliance with the IFR would result in a "significant decrease in access to benefits" or a "significant increase in premiums;" and c. The plan or issuer understands and will comply with the requirement to provide an annual notice to consumers as outlined in section V of CCIIO's June 17, 2011 Supplemental Guidance. 3. In accordance with CCIIO's September 3, 2010 Guidance, the signature of the attestation must be provided by: a. the Chief Executive Officer of the issuer if the application is prepared on behalf of a Fully-Insured plan or policy;			

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		or b. the plan administrator if the application is prepared on behalf of a Self-Insured plan. 4. If the attestation is prepared by a third-party administrator (TPA) or consultant, the same attestation rules apply. **A TPA or consultant may not sign the attestation**. An officer or benefits administrator at the client company must sign the attestation instead. 5. Email complete elections to: AnnualLimitExtension@cms.hhs.gov and make **"Waiver Extension"** the subject heading. (Note: this is a different email address from that used by New Applicants). a. A complete election consists of (1) the Waiver Extension form spreadsheet; and (2) a signed attestation. b. Only electronic submissions will be accepted. Spreadsheets will only be accepted in .xls or .xlsx format. CCIIO will not accept the spreadsheet in a .pdf format. 6. CCIIO will begin accepting elections for Waiver Extensions on **June 24, 2011**. The deadline to submit elections is **September 22, 2011.** Existing waiver recipients opting to			

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		submit an election will receive an email message confirming receipt of the application. Group health plans and health insurance issuers should not expect to be contacted by CCIIO unless the election for the Waiver Extension is incomplete. Upon receipt of complete Waiver Extension materials, CCIIO will consider the waiver extension valid until the plan or policy year beginning on or after January 1, 2014. No letter of acknowledgment will be issued to this effect. **No waivers will be extended for Waiver Extension elections received after September 22, 2011. These waiver recipients' plans or policies must come into compliance with section 2711 of the PHS Act, as amended by the Affordable Care Act, and the interim final regulations (IFR) (codified at 26 C.F.R. § 54.9815-2711T; 29 C.F.R. § 2590.715-2711; and 45 C.F.R. § 147.126) when their current plan year ends.** As a condition of extending the waiver, a health insurance issuer or group health plan electing a Waiver Extension must file two Annual Limit Updates: the first is due by December 31, 2012; and the second is due by December 31, 2013. The Annual Limit Update must include the same materials as are required for a Waiver Extension; the recipient of the Waiver Extension must update the			

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		information requested in the "Waiver Extension Form" document and provide an updated attestation (see Attestation in section V of these Technical Instructions). In addition, waiver recipients electing Waiver Extensions must retain all records pertaining to their applications to permit HHS to conduct an audit of the waiver applications. HHS may, in its discretion, withdraw a waiver based on the failure of the waiver recipient to comply with any of these conditions. **State Waiver Recipients** The process for applying for a State-mandated limited benefit plan was outlined in CCIIO's November 5, 2010 Guidance (CCIIO 2010-1A). States that have applied for and been granted a waiver on behalf of issuers offering state-mandated limited benefits are also eligible for waiver extensions. States should follow the procedure outlined above for submitting the Waiver Extension form. In lieu of an attestation from each issuer's Chief Executive Officer, the State may submit a statement from the State's insurance commissioner or another State official that the State-mandated policy was in existence prior to September 23, 2010, and that compliance with section 2711 of the PHS Act would result in a significant decrease in access to benefits or a			

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		significant increase in premiums for each issuer on whose behalf the State is applying.			
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q2:** How Do I Apply For A New Waiver?	**A2:** New Applicant is a group health plan or health insurance issuer that was in existence prior to September 23, 2010 and has not yet applied for, or has not yet received, a waiver of annual limits prior to June 17, 2011, with: 1) A plan year (or policy year, in the individual market) beginning on or after September 23, 2010 but before September 23, 2011 that is unable to meet the $750,000 annual limit requirement; or 2) A plan year (or policy year, in the individual market) beginning on or after September 23, 2011 but before September 23, 2012 that is unable to meet the $1.25 million annual limit requirement; or 3) A plan year (or policy year, in the individual market) beginning on or after September 23, 2012 but before January 1, 2014 that is unable to meet the $2 million annual limit requirement. New Applicants must follow the steps below when applying for a waiver of their annual limits. 1. Obtain a copy of the Excel spreadsheet entitled “Annual Limit Waiver - New Application” from the	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf

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		Annual Limit Waivers website at the following URL: http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html. a. Every cell of a row of this spreadsheet must have an entry for each plan or policy, and each tier thereof, as described in the document entitled "Data Dictionary." The Data Dictionary is also available at the Annual Limit Waivers website at: http://cciio.cms.gov/programs/marketreforms/annuallimit/index.html. b. The spreadsheet requests information about the applicant, including contact information; benefit structure; current annual limit(s); and, if applicable, a description of the decrease in access to benefits that would occur if the waiver is not granted. c. The categories of "Essential Health Benefits" are based on section 1302(b) of the Affordable Care Act. Because the specific services and benefits falling within the ten general categories have not yet been defined, CCIIO will accept a group health plan or health insurance issuer's good-faith determination as to whether a particular benefit is an essential health benefit. d. If the plan or policy benefit design includes lifetime limits on essential			

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		health benefits, applicants must state in their submission emails that they are waiving all lifetime limits on essential health benefits pursuant to section 2711 of the Affordable Care Act. **No lifetime limits on essential health benefits are permissible**. A waiver application will not be processed if there are lifetime limits of essential health benefits on a plan or policy and this acknowledgment is not made in the application. 2. In a separate document, the applicant should also provide the language from the attestation in section V of these Technical Instructions, using the "New Applicant" language. The attestation certifies: a. A group health plan or issuer's policy was in existence prior to September 23, 2010; b. Compliance with the IFR would result in a "significant decrease in access to benefits" or a "significant increase in premiums;" and c. The plan or issuer understands and will comply with the annual notice to consumer requirements as outlined in section V of CCIIO's June 17, 2011 Supplemental Guidance. Revised August 19, 2011 5 **3.** In accordance with CCIIO's September 3, 2010 Supplemental			

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		Guidance, the signature of the attestation must be provided by: a. The Chief Executive Officer of the issuer if the application is prepared on behalf of a Fully-Insured plan or policy; or **b.** The plan administrator if the application is prepared on behalf of a Self-Insured plan. **c.** If the attestation is prepared by a third-party administrator (TPA) or consultant, the same attestation rules apply: **a TPA or consultant may not sign the attestation**. If the TPA is considered the plan administrator, an officer or benefits administrator at the client company must sign the attestation. **4.** Applications may also provide supplemental information to evidence how compliance with the annual limit requirements of section 2711 of the PHS Act, as amended by the Affordable Care Act, and the IFR will lead to a significant decrease in access to benefits or significant increase in premiums for enrollees. This may take the form of a letter or statement describing how benefits may decrease or premiums will increase if a waiver is not granted. It should accompany the Annual Limit Waiver – New Application form and may be appended to the attestation.			

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		Supplementary materials are not mandatory but may be helpful to CCIIO to arrive at a decision. **5**. Email complete applications to AnnualLimitWaiver@cms.hhs.gov and make **"New Waiver Application"** the subject heading. (Note: this is a different email address from that used by Waiver Extensions). a. A complete application consists of: (1) the New Annual Limit Waiver Application form; (2) a signed attestation; and (3) any supplementary materials you wish to provide. **b.** Only electronic applications will be accepted. Spreadsheets will only be accepted in .xls or .xlsx format. CCIIO will not accept the spreadsheet in a .pdf format. **c.** As of June 17, 2011, CCIIO will stop accepting waiver applications based on prior CCIIO application forms. CCIIO will begin accepting applications from New Applicants on **June 24, 2011**. The deadline to submit applications is **September 22, 2011**. New Applicants should also consult CCIIO's November 5, 2010 Supplemental Guidance, which sets forth the factors that are considered when determining whether an application demonstrates a "significant increase in premium" or a "significant			

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		decrease in access to benefits." This Guidance is available at the following URL: http://cciio.cms.gov/resources/files/annual_limits_waiver_guidance.pdf. **No waivers will be granted for new Waiver Applications received after September 22, 2011. Applications received after September 22, 2011 will not be accepted, and those applicants' plans or policies must come into compliance with section 2711 of the PHS Act, as amended by the Affordable Care Act, and the IFR.** If a New Applicant is granted a waiver, the waiver is valid until the plan or policy year beginning on or after January 1, 2014, provided the applicant comply with the Annual Limit Update and Annual Notice requirements detailed in the June 17, 2010 Supplemental Guidance. New Applicants, as a condition of extending their waivers, must file two annual updates of the Annual Limit Update: the first is due by December 31, 2012; and the second is due by December 31, 2013 (as detailed in Section II above). In addition, New Applicants must retain all records pertaining to their applications to permit HHS to conduct an audit of the waiver applications. HHS may, in its discretion, withdraw a waiver based on the failure of the applicant to comply with any of these			

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		conditions. **New State Applicants** If a State wishes to obtain a waiver for a State-mandated limited benefit plan, it should follow the above procedures. Special guidance for States may also be found in CCIIO's November 5, 2010 Guidance, available at the following URL: http://cciio.cms.gov/resources/files/annual_limits_waiver_guidance.pdf. In lieu of an attestation from each issuer's Chief Executive Officer, the State may submit a statement from the State's insurance commissioner or another State official that the State-mandated policy was in existence prior to September 23, 2010, and that compliance with section 2711 of the PHS Act would result in a significant decrease in access to benefits or a significant increase in premiums for each issuer on whose behalf the State is applying.			
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q3:** Is My Plan or Policy a New Applicant or an Existing Waiver Recipient?	If it is unclear whether a group health plan or issuer's policy should follow the guidelines for a New Applicant or for an Existing Waiver recipient, please review the following scenarios to determine whether you should comply with the New Application Process or Waiver Extension Process. **A. What If I Applied For a Waiver on**	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf

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		Behalf of My Plan or Policy with an Annual Limit Below $750,000, and the Waiver was Denied? If you are a group health plan or health insurance issuer that applied for a waiver, and a waiver was denied for your plan or policy year beginning between September 23, 2010 and September 22, 2011, you may either apply for a waiver of the annual limits requirement of $1.25 million or $2 million, or come into compliance with section 2711 of the PHS Act and the IFR. If you choose to apply for a waiver of the restricted annual limits requirement of $1.25 million, for plan years (or, in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012, and $2 million for plan years (or, in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013, you will be considered a New Applicant. Please follow the application instructions detailed above for New Applicants (or see the chart in Section IV of these Technical Instructions, summarizing all requirements). **B. What If My Plan or Policy With an Annual Limit Below $750,000 Has Some Plans or Policies That Were Approved and Some Plans or Policies That Were Denied?**			

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		If you are a group health plan or health insurance issuer that applied for a waiver, and were approved and denied for some plans or policies, you should file both a New Application and a Waiver Extension form. For plans or policies that were denied for plan years beginning between September 23, 2010 and September 22, 2011, you may either apply for a waiver of the annual limits requirement of $1.25 million or $2 million for those plans (as outlined in Section III. A above), or come into compliance with section 2711 of the PHS Act and the IFR. If you choose to apply for a waiver of the restricted annual limits requirement of $1.25 million, for the plan years (or in the individual market, policy years) beginning between September 23, 2011 and September 22, 2012, and $2 million for plan years (or in the individual market, policy years) beginning between September 23, 2012 and December 31, 2013, you will be considered a New Applicant. Please follow the application instructions detailed above for New Applicants for the denied plans or policies. Your approved plans and policies are eligible for a Waiver Extension. You must either elect to extend your waiver of the annual limits requirements or come into compliance with section 2711 of the PHS Act and the IFR when your			

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		waiver expires. Please follow the application instructions detailed above for Waiver Extensions for the approved plans or policies. **C. What if My Plan or Policy has an Annual Limit below $750,000 and I Applied Prior to June 17, 2011, But I Receive a Waiver Approval *after* June 17, 2011?** If you are a group health plan or health insurance issuer that applied for a waiver prior to June 17, 2011, and you receive an approval after June 17, 2011, you will be considered a **New Applicant who has already submitted an application through the end of the plan or policy year beginning before January 1, 2014**. If approved for a waiver of annual limits, your remaining requirements to extend your waiver are the two annual submissions of the Annual Limit Updates (due by December 31, 2012 and December 31, 2013). **D. What if My Plan or Policy has an Annual Limit below $750,000 and I Applied Prior to June 17, 2011, And I Received a Waiver Approval *before* June 17, 2011?** If you are a group health plan or health insurance issuer that applied for a			

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		waiver prior to June 17, 2011 and received an approval prior to June 17, 2011, you are eligible for an extension of your existing waiver. Please follow the application instructions detailed above for Waiver Extensions. **E. What if My Plan or Policy has an Annual Limit below $750,000 and I Have Not Yet Applied For a Waiver?** If you are a group health plan or health insurance issuer with annual limit(s) below $750,000, and you have not applied for a waiver for your plan or policy year beginning between September 23, 2010 and September 22, 2011, you are considered a New Applicant. You must either apply for a waiver of the annual limits requirements by September 22, 2011, or come into compliance with section 2711 of the PHS Act and the IFR. No new waiver applications will be accepted after September 22, 2011. Please follow the application instructions detailed above for New Applicants. If you are granted a waiver for an application submitted after June 24, 2011 and before September 22, 2011, you will have satisfied the application deadline for New Applicants, and your remaining requirements to extend your waiver are the two submissions of the Annual Limit Updates (due by			

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		December 31, 2012 and December 31, 2013). **F. I'm a Non-Federal Governmental Plan. Do I Have to Apply for a Waiver?** A non-federal governmental plan, except for those offering excepted benefits, as defined in section 2791 of the PHS Act, must comply with the restricted annual limit requirements. If you have already received a waiver, please follow the Waiver Extension instructions. If not, please follow the New Applicant instructions.			
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q4:** What are My Deadlines?	**A4:** It is important to understand the deadlines that affect your plans and policies. The chart below summarizes important deadlines for New Applicants who have never applied for waivers, and for existing waiver recipients who elect to submit Waiver Extensions. To see chart, please see click on link below and see page 9 : http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q5:** What Do I Need to Include in the Attestation?	**A5**: The language of this attestation must be used by both New Applicants and existing waiver recipients. **With the exception of State applicants, the**	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf

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		language in the Attestation must be used by applicants. CCIIO no longer accepts attestation language developed by the applicant. Please ensure that the individual signing the attestation reads it thoroughly and is aware of what it is to which they attest, particularly if he or she is not the party who has prepared the application. **Required Attestation Language**; I, _____ [print name of attestor], attest that the information contained in this application is accurate to the best of my knowledge, and that the following is true: 1. My plan(s) or polic(y)(ies) [was/were] in existence prior to September 23, 2010. 2. Compliance with 45 C.F.R. § 147.126 would result in [list one or both] a significant decrease in access to benefits [and/or] a significant increase in premiums. 3. The plan(s) or issuer understands and will comply with the updated annual notice requirements as outlined in section V of the June 17, 2011 Supplemental Guidance (CCIIO 2011-1D). I am also aware that a material misrepresentation or misstatement in this application may result in the Department of Health and Human Services withdrawing a waiver if one is granted to the plan or issuer of the			

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		policy. If the plan or issuer on behalf of which I now attest receives a waiver, I am aware that failure to provide Annual Limit Updates, pursuant to the Center for Consumer Information and Insurance Oversight's June 17, 2011 Supplemental Guidance, may result in the Department of Health and Human Services withdrawing a waiver. _____, _____ (Signature) (Date) _____ (Title			
Technical Instructions for the Waiver Extension and Waiver Application Process	**Q6:** Update for Health Reimbursement Arrangements (HRAs)	**A6.** Supplemental Guidance published on August 19, 2011 exempts as a class all HRAs that are subject to the requirements of section 2711 and that were in effect prior to September 23, 2010 from having to apply individually for an annual limit waiver for plan years beginning on or after This exemption was granted because HRAs set limits on the amount that can be spent and, CCIIO believes, those limits would always be less than the applicable restricted annual limit amounts. However, an HRA that is exempt from applying for an annual limit waiver still must comply with the record retention requirement and the Annual Notice requirement to participants and subscribers, which is necessary for consumers to understand the value and quality of the coverage they have.	FAQ March 29, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ancillary-product-faq-03-29-201.pdf

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		CCIIO has drafted alternate Annual Notice language for HRAs that have not yet issued their Annual Notice. The following criteria apply: • The notice must be printed in 14-point, bold font on the front of plan materials. • The notice applies to HRA applicants who have received a Waiver Extension as well as the HRAs exempt from applying pursuant to the August 18, 2011 Supplemental Guidance. • The notice must be provided to new eligible participants and subscribers and at the beginning of the plan year. If the plan year has already begun and notice has not been issued, it must be provided within 60 days of the date of this publication. • The following language shall be used to satisfy the notice requirement: This exemption was granted because HRAs set limits on the amount that can be spent and, CCIIO believes, those limits would always be less than the applicable restricted annual limit amounts. **The Affordable Care Act prohibits health plans from applying dollar limits below a specific amount on coverage for certain benefits. This year, if a plan applies a dollar limit on the coverage it provides for certain benefits in a year, that limit must be at least [$750,000/$1.25 million/$2 million as applicable].** **Your health coverage offered by**			

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		[name of group health plan/applicant], does not meet the minimum standards required by the Affordable Care Act described above. Your employer makes an annual contribution of: **[Dollar amount] to your Health Reimbursement Arrangement (HRA). This means your health coverage may not pay for all the health care expenses you may incur.** **The U.S. Department of Health and Human Services has granted your HRA a waiver from the requirement that it provide [$750,000/$1.25 million/$2 million] in benefits until [the end date of the last plan or policy year beginning before January 1, 2014] because it would cause a significant decrease in your access to this benefit. If you are concerned about your plan's lower dollar limits on key benefits, you and your family may have other options for health care coverage. For more information, go to: www.HealthCare.gov.** **If you have any questions or concerns about this notice, contact [provide contact information for plan administrator]. [For plans offered in States with a Consumer Assistance Program] Additionally, you can contact [contact information for Consumer Assistance Program].** If an employer that maintains an HRA			

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		also maintains other coverage, whether or not that coverage is integrated with the HRA, that other coverage must meet the requirements of section 2711 of the PHS Act or obtain a waiver.4If approved, the underlying group health plan would meet the notice requirement by printing the notice language from the June 17, 2011 guidance on its plan materials that describe the terms of coverage. Additionally, an HRA that has already received a waiver and issued the Annual Notice printed in the June 17, 2011 Guidance does not need to re-issue the new notice. Finally, HRAs that have already applied for, and been granted, a waiver need not apply for an extension. This exemption will remain in effect through plan years beginning before January 1, 2014. If you have any questions regarding this update, please e-mail the CCIIO mailbox at AnnualLimitWaiver@cms.hhs.gov (use "HRA Exemption" as the subject of the email).			
Essential Community Providers	**Q1:** What should providers that serve predominantly low-income, medically underserved individuals be aware of as issuers build their qualified health plan (QHP)	**A1:** Issuers (health insurance companies) are currently building their provider networks to meet new requirements set by the Affordable Care Act (ACA) and may be seeking participation. A provider's uninsured patients may be eligible to participate in and purchase insurance via the Health Insurance Marketplace in your state.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf

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	networks?	Issuers that offer plans on the Health Insurance Marketplaces (sometimes called Exchanges) now have a requirement under the Affordable Care Act to include in their network a sufficient number and geographic distribution of providers that serve predominately low-income, medically underserved individuals (referred to as Essential Community Providers (ECPs).			
Essential Community Providers	**Q2:** What does this mean for providers that serve predominantly low-income, medically underserved individuals?	**A2:** At this time, CMS is simply alerting providers that serve predominantly low-income and medically underserved individuals of an important potential new opportunity to participate in a QHP issuer's network. Issuer requirements of providers serving in their networks will vary.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf

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Essential Community Providers	**Q3:** Is there a list of ECPs?	**A3:** A non-exhaustive database of ECPs is available at https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq. See http://www.cciio.cms.gov/programs/Files/ecp-listing-cover-sheet-03262013.pdf for a cover sheet explaining the database.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q4:** Will issuers be able to write in ECPs that are not on the list?	**A4:** Yes, CMS realizes that the list is not exhaustive and that issuers may identify and write in other providers who meet the regulatory standard.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q5:** Is an issuer seeking QHP certification required to do business with my organization?	**A5:** No, but there is a new requirement for QHP issuers to include a sufficient number and geographic distribution of ECPs in their provider networks participating in the Health Insurance Marketplaces. For Federally-facilitated and State Partnership Marketplaces, this is described in CMS' "Letter to Issuers on Federally-facilitated and State Partnership Exchanges", available at: http://cciio.cms.gov/resources/regulatio	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf

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		ns/Files/2014_letter_to_issuers_04052013.pdf. The Letter to Issuers provides additional background on the ECP requirement. It also notes the expectation that issuers failing to meet a "Safe Harbor" or "Minimum Expectation" standard will offer a narrative justification explaining how the provider network(s) will provide an adequate level of service for low-income and medically underserved enrollees consistent with the regulatory standard. CMS also reserves the right to monitor issuers on a post-certification basis to ensure sufficient ECP participation.			
Essential Community Providers	**Q6:** How does CMS determine what are considered "available" ECPs?	**A6:** For Federally-facilitated and State Partnership Marketplaces, CMS will use the non-exhaustive database of ECPs found at https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq as the basis for determining the number of available ECPs in the Qualified Health Plan's (QHP's) service area. This would form the denominator of the percentage of available ECPs included in the issuer's provider networks(s), as referenced in the Letter to Issuers.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q7:** Who should I contact with questions?	**A7:** If you have questions, please direct them to: essentialcommunityproviders@cms.hhs.gov	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf

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Essential Community Providers	**Q8:** Where can we find information on the ACA and the ECP program?	**A8:** Please use the following link to obtain additional information on the Affordable Care Act and on the ECP inclusion standard as contained in the "Letter to Issuers on Federally-facilitated and State Partnership Exchanges": http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. If you are located in a state that will operate a State-based Marketplace, please contact the entity that is operating the Marketplace for more information on how the ECP provisions of the Affordable Care Act will be applied in the state. We also suggest identifying and contacting your state's association of insurance issuers.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q9:** Where can we find information on the insurance coverage offered on the Marketplaces?	**A9:** Please use the following link to obtain more information: http://www.healthcare.gov/. Please note that the actual QHPs that will be offered on the Marketplaces will not be available for enrollment until October 1, 2013.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q10:** What is the timeline for this process, and is it too late to contract with issuers?	**A10:** Issuers will be applying for certification as QHPs through the month of April, but building and maintaining a network will be an ongoing process. The Marketplaces will be available for enrollment starting on October 1, 2013, with initial coverage effective as of January 1, 2014.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community	**Q11:** Who should	**A11:** The QHPs that will be offered on	FAQ May, 13,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Providers	potential ECPs contact in their state to get more information about potential QHPs?	the Marketplaces will not be certified until later this year. In the meantime, potential ECPs should contact the insurance carriers' association in their state, which may be aware of health insurance products being submitted for QHP certification. Finally, we also recommend that potential ECPs identify health insurance issuers with the greatest market share in the individual and small group markets, and reach out to those issuers directly.	2013		act-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Essential Community Providers	**Q12:** How was the Minimum Expectation threshold chosen?	**A12:** Recognizing that it typically takes issuers 12-18 months to fully contract their networks, we are evaluating issuers using the Safe Harbor standard and Minimum Expectation level (as described in the Letter to Issuers) for Federally-facilitated and State Partnership Marketplaces in the 2014 coverage year. CMS will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.	FAQ May, 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ecp-faq-20130513.pdf
Oversight of Premium Stabilization Programs, Advance Payments of the Premium Tax Credit, and Cost-sharing Reductions	**Q1:** What oversight activities does the Centers for Medicare & Medicaid Services (CMS) intend to propose with respect to the state-operated risk adjustment and	**A1:** We intend to propose monitoring and oversight measures related to the premium stabilization programs applicable to both states and issuers. With respect to state-operated risk adjustment programs, we intend to propose a standard under which the state would maintain an accurate accounting	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf

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	reinsurance programs, cost-sharing reductions, and advance payments of the premium tax credit?	for each benefit year of risk adjustment expenditures, receipts, and administrative expenses, and the state would provide to CMS and make public an annual summary of the program. We also intend to propose that each state-operated risk adjustment program provide for an annual external financial and programmatic audit, and maintain relevant records for ten years. We intend to propose oversight standards applicable to states operating reinsurance programs that are substantially similar to those discussed above for state-operated risk adjustment programs. With respect to advance payments of the premium tax credit and cost-sharing reductions, we intend to propose standards for reimbursement to eligible enrollees, and providers as applicable, when a QHP issuer incorrectly applies cost-sharing reductions or advance payments of the premium tax credit with respect to an enrollee. We also intend to propose standards relating to record retention, annual reporting, and audits.			
Oversight of Premium Stabilization Programs, Advance Payments of the Premium Tax Credit, and Cost-sharing Reductions	**Q2:** How will CMS ensure that issuers of a risk-adjustment covered plan or reinsurance-eligible plan establish a distributed data environment?	**A2:** We intend to propose enforcement of distributed data environment standards through civil money penalties. In addition, with respect to risk adjustment, we intend to propose a default risk charge that would apply to plans that fail to establish a secure, distributed data environment or			

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		otherwise fail to provide risk adjustment data required for the calculation of risk adjustment payment transfers.			
Issuer Oversight	**Q3:** How does the Federally Facilitated Marketplace intend to enforce issuers' ongoing compliance with Marketplace-specific standards?	**A3:** We expect that state departments of insurance will continue to oversee issuers in the health insurance market pursuant to the respective states' existing law and regulations. We intend to coordinate with state monitoring and oversight efforts to avoid duplicating such efforts, to the extent feasible and appropriate. As mentioned in prior FAQs, (http://www.cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html), we intend to – 2 – continue assisting issuers to maintain compliance with Marketplace standards. To that end, we expect to release guidance reflecting this approach in the near future.	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf
Issuer Oversight	**Q4:** Under what circumstances are issuers in the Federally-facilitated Marketplace subject to enforcement actions, including decertification of their QHPs?	**A4:** We intend to take an enforcement approach that would take into consideration various factors, including any past or concurrent state determinations and indications of the issuer's good faith efforts in maintaining compliance with standards specific to the Federally-facilitated Marketplace. We note the need to coordinate with states on issuer oversight to avoid duplicative enforcement or investigative actions for the same issue, to the extent feasible and appropriate. We will			

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		generally look to the states to enforce standards applicable to issuers in the Federally-facilitated Marketplace. Where a state has elected not to enforce a standard or lacks the regulatory or enforcement authority to do so, we intend to propose enforcement of Federally-facilitated Marketplace-specific standards through civil money penalties (CMPs) and decertification. Absent any extraordinary circumstances, we expect decertification would be uncommon. We also intend for issuers to be able to appeal the issuance of CMPs or decertifications.			
State-based Marketplace Reporting Requirements	**Q5:** Will State-based Marketplaces be required to provide reports to CMS on Marketplace activities?	**A5:** Yes, we intend to propose requiring State-based Marketplaces to submit reports to CMS at least annually, including but not limited to financial statements and summary-level statistical reports regarding eligibility determinations, enrollments, appeals, eligibility determination errors, privacy and security safeguards, and fraud and abuse determinations. Additionally, we intend for State-based Marketplaces to submit performance monitoring data including financial sustainability, operational efficiency, consumer satisfaction, and quality of care data.	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf
State-based Marketplace Reporting Requirements	**Q6:** Are there any recordkeeping requirements for State-based	**A6:** Yes, we intend to propose that State-based Marketplaces will be required to maintain for a minimum of 10 years records related to external			

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	Marketplaces?	audits, annual financial reports, error rate testing, consumer complaints, and other data sources in anticipation of targeted audits.			
State-based Marketplace Reporting Requirements	**Q7:** What types of audits will State-based Marketplaces be required to conduct?	**A7:** We intend to propose that State-based Marketplaces engage an independent qualified auditing entity to perform an independent audit of their annual financial statements and a review of the process/internal controls associated with their eligibility determinations and enrollments. We further intend to propose that State-based Marketplaces will be required to provide the results of this financial and programmatic audit to CMS.			
Privacy and Security	**Q8:** Will CMS create additional security standards for State-based Marketplaces and non-Marketplace entities such as Navigators, agents, brokers, and other assistance personnel?	**A8:** We intend to propose that compliance with the security standards defined in the Minimum Acceptable Risk Standards for Marketplaces (MARS-E) suite of documents be a requirement for all SBMs and non-marketplace entities associated with the Federally-facilitated Marketplace.– 3 – We also propose clarifying that the security standards apply to all information that is used for Marketplace functions and not only to personally identifiable information.	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf
Cost-Sharing Reductions and Health Savings Accounts	**Q9:** How should plan variations for QHPs that are high-deductible health plans (HDHPs)	**A9:** If an issuer seeks to offer a QHP designed to be eligible for pairing with an HSA in 2014, the issuer must comply with the cost-sharing reduction standards described in 45 CFR 156	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf

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	designed to be paired with a health savings account (HSA) be structured?	subpart E. CMS recognizes that certain plan variations of a QHP may require a low or zero deductible, or that certain services be exempt from the deductible. This may result in the plan variation not meeting IRS standards for an HDHP and therefore not being eligible to be offered in conjunction with an HSA. We recommend that issuers and Marketplaces educate consumers about this issue, both during open enrollment and when an individual has a change in eligibility for cost-sharing reductions. An individual who would not be eligible for the tax advantages of an HSA because the plan variation to which he or she would be assigned does not qualify as an HDHP may purchase the plan without cost-sharing reductions.			
Eligibility and Enrollment	**Q10:** Will issuers be required to obtain a Health Plan Identifier (HPID) to conduct enrollment and payment transactions with Federally-facilitated Marketplace?	**A10:** CMS intends to propose rulemaking and supplemental guidance on the use of HPIDs in enrollment and payment transactions between issuers and the Federally-facilitated Marketplace. A standard for HPIDs was adopted by HHS in a September 5, 2012 final rule at 77 FR 54664,1 and the system to enable insurance issuers to obtain an HPID has been available since March 28, 2013. All health plans are required to obtain HPIDs by November 5, 2014 (small plans have until November 5, 2015). All HIPAA covered entities—health care clearinghouses, covered	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf

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		health care providers, and health plans—are required to use HPIDs to identify health plans in standard transactions such as claims, referrals, and remittance advice by November 7, 2016. Since an issuer can obtain and use an HPID in advance of the compliance dates specified in the September 5, 2012 final rule, beginning in October 2013, the Federally-facilitated Marketplace anticipates requiring the issuers to have obtained HPIDs. The Federally-facilitated Marketplace will use them to route the electronic transactions correctly. We expect the HPID will be used in the "envelope" of the enrollment and payment transactions to ensure that they successfully reach the right issuer or its designated trading partner. Issuers may be able to limit the number of HPIDs they obtain to those needed for routing purposes to do business with the Federally-facilitated Marketplace, as long as they do so in accordance with the HPID regulation. Each of the issuer's QHPs will be associated with an HPID, but the HPIDs need not be unique for each QHP. An issuer that is a controlling health plan (CHP), as defined by 45 CFR 162.103, could decide to use its HPID for all transactions. Third party entities, such as clearinghouses, are also able to obtain			

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		an Other Entity Identifier (OEID) at this time. If an issuer utilizes a third party for processing its transactions, issuers would be able to use the OEID of the contracted party to identify where transactions would be routed. For more information on HPID, visit http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Affordable-Care-Act/Health-Plan-Identifier.html.			
Issuer Withdrawal from the Small Group or Large Group Market	**Q11:** May an issuer elect to discontinue offering all products in the small group market in a state but continue to offer products in the large group market in that state (and vice versa)?	**A11:** Yes. Although the final rule2 implementing PHS Act section 2703, as added by the Affordable Care Act, addressed the market withdrawal exception to guaranteed renewability only with reference to the individual and "group" market, we intend to propose amendments in future rulemaking that recognize the distinction between the large group and small group market segments for purposes of PHS Act section 2703. Accordingly, an issuer could, in accordance with applicable state law and subject to the other requirements of 45 CFR 147.106(d), satisfy the requirement in 45 CFR 147.106(d) to discontinue offering all coverage by doing so with respect to either the large group or small group market without being required to withdraw from both segments of the group market.	FAQ May 14, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-faq-5-14-2013.pdf
Eligible and Ineligible	**Q1:** Who can apply	**A1:** Self-employed individuals and	FAQ April 9,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Applicants	for this FOA?	private and public entities proposing to operate as Marketplace Navigators in states with a Federally-facilitated and State Partnership Marketplace are eligible to apply. At least two types of entities will serve as Navigators in each Marketplace, and at least one type of Navigator entity will be a community and consumer- focused nonprofit. Other entities may include, but are not limited to, trade, industry and professional associations; commercial fishing industry organizations; ranching and farming organizations; chambers of commerce; unions; resource partners of the Small Business Administration; licensed insurance agents and brokers; Indian Tribes, tribal organizations, and urban Indian organizations; State or local human services agencies; and other public or private entities.	2013		act-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q2:** Can Agents and Brokers apply for funds under this funding opportunity announcement (FOA)?	**A2:** Licensed agents and brokers are eligible to apply, however, during their term as Navigators, individuals and entities are not permitted to receive any direct or indirect consideration from a health insurance issuer connected to the enrollment of individuals into Qualified Health Plans (QHPs) or non-QHPs. The preamble to the Exchange Final Rule defines “consideration” as financial compensation, including monetary or in-kind of any type,	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		including grants, as well as any other types of influence a health insurance issuer could use, including but not limited to things such as gifts and free travel, which may result in steering individuals to particular QHPs offered in the Exchange or plans outside of the Exchange (77 FR 18333).			
Eligible and Ineligible Applicants	**Q3:** Is there anyone who is ineligible to apply for this FOA?	**A3:** Yes, health insurance issuers, subsidiaries of health insurance issuers, associations that include members of, or lobby on behalf of, the insurance industry; or recipients of any direct or indirect consideration from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or non-QHP.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q4:** Are there any additional requirements after awards are made to ensure that I/we remain eligible throughout the course of the project period?	**A4:** Yes, awardees must meet reporting and certification deadlines to be eligible throughout the project period. Information about reporting and certification will be provided with the Notice of Award for the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplaces.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q5:** Are tribal entities eligible to apply under this announcement?	**A5:** Indian Tribes, tribal organizations, and urban Indian organizations are eligible to apply as specified in the FOA under Section III. 1, Eligible Applicants.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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Eligible and Ineligible Applicants	**Q6:** Are individuals eligible to apply to be a Navigator?	**A6:** Yes, please see pages 14-15 of the Navigator FOA. In order for an individual to be eligible, they must be self-employed and have an EIN/TIN number [Employer Identification Number/Taxpayer Identification Number], which is necessary for submission of the application on www.grants.gov.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q7:** Can a state-run or public hospital apply to be a Navigator? What if it receives payment from an issuer for services rendered?	**A7:** Hospitals are generally considered eligible to apply for Navigator funding. The prohibition on receiving direct or indirect consideration from a health insurance issuer applies to consideration received for enrolling individuals or employees in health insurance plans, such as an agent or broker commission. It is possible, under the Notice of Proposed Rulemaking (NRPM) for Navigator Standards, that such a hospital would be required to disclose to the Marketplace and consumers any issuer funds it receives that are unrelated to the enrollment of individuals or employees into health insurance plans, but this would not be a bar to applying. If, however, the hospital is a state-run hospital in a State Partnership Marketplace, is a subsidiary of a health insurance issuer, or if it receives direct or indirect compensation related to enrollment from a health insurance issuer then it would be ineligible to apply.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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Eligible and Ineligible Applicants	**Q8:** Is an entity that sells Medicaid or Medicare plans eligible to apply to be a Navigator?	**A8:** If an applying entity or one of its corporate affiliates is required to be licensed to engage in the business of insurance in a state and are subject to state law that regulates insurance, you might be a health insurance issuer or have a relationship with a health insurance issuer that would make you ineligible for a Navigator grant. See definition of "health insurance issuer" at 45 C.F.R. §§ 155.20 and 144.103. CMS will evaluate specific corporate structures on a case by case basis. The FOA requires applicants to submit a brief statement attesting that they are not an ineligible entity; please keep the foregoing guidance in mind when drafting that statement (for example, by disclosing any corporate relationships with an entity that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q9:** If my organization self-insures, does this make us ineligible to be a Navigator?	**A9:** No, providing health insurance to employees on a self-insured basis does not necessarily make you and entity that would fall within the definition of a "health insurance issuer" in the Exchange Rules and Public Health Service Act.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q10:** Can a state or county agency apply?	**A10:** Please see page 14 of the Navigator FOA. No state agency in a state where there is a Consumer Partnership Marketplace may apply for	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		a Navigator cooperative agreement. HHS will evaluate on a case by case basis whether counties may apply in such states. State and county agencies in states that will not have a State Partnership Marketplace are welcome to apply.			
Eligible and Ineligible Applicants	**Q11:** Can someone apply more than once, for example, as an individual and as part of a consortium, or as part of multiple consortia?	**A11:** An individual can apply both individually and as part of a consortium, or as part of multiple consortia, however, the applicant would need to be mindful when preparing their applications of the possibility of receiving both awards. To be prepared to carry out both grant proposals, the applicant would need to budget their time accordingly in each proposed work plan and budget, reflecting the portion of time the applicant would spend on each project if both are selected for an award.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q12:** Can a consortium with multiple entities divide the duties of a Navigator so that one group is performing some of the duties and another group is performing other duties?	**A12:** No. We will expect all entities serving in a consortium to perform all of the duties of a Navigator. This includes the lead applicant of a consortium proposing to serve as the administrator for the Navigator cooperative agreement. An entity may meet this requirement in different ways, however. For example, while the lead agency applying for Navigator funds and all members of a consortium would be required to perform all of the duties of	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		the Navigator (listed on page 6 of the FOA), we recognize that different members of a consortium may have expertise in different areas, such as outreach and education or facilitating enrollment. As such, while all organizations forming a consortium would have to perform all duties associated with receiving the cooperative agreement award, there is no requirement that each consortium member perform all of the duties with the same focus. Each Navigator cooperative agreement awardee and awardee staff members who carry out Navigator functions should have the ability to help any individual who presents themselves for assistance. Additionally, we expect that all staff associated with a Navigator cooperative agreement who will be carrying out Navigator duties would be trained, in accordance with the standards proposed in the Notice of Proposed Rulemaking for Navigator Standards, to perform all of the duties of a Navigator and would be equipped to assist consumers through outreach, education, and during the eligibility and enrollment processes.			

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Eligible and Ineligible Applicants	**Q13:** Must the recipient of a Navigator cooperative agreement perform all of the required Navigator duties equally or can they focus on one duty more than another?	**A13:** The recipient of a Navigator cooperative agreement must place equal emphasis on all of the required duties of a Navigator; however, if a consortium is working together, it is the consortium as a whole that must perform the required duties with equal emphasis.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q14:** Can a consortium appoint a lead entity that is responsible for managing the other members of the consortium and that does not perform any of the Navigator duties?	**A14:** No. We would expect all members of a consortium receiving an award to be able to perform all required Navigator duties. The lead applicant may budget for costs associated with the managing and coordination of consortium members, but must still perform all Navigator duties as well.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Eligible and Ineligible Applicants	**Q15:** If a consortium applying for a Navigator cooperative agreement includes multiple types of entities (including a community or consumer-focused non-profit), can that consortium apply for all of the funds	**A15:** No. This scenario would not meet the Navigator regulatory requirement that at least two types of entities, at least one of which must be a consumer or community-focused non-profit, receive a cooperative agreement in a state. A consortium will count as one entity and only the lead agency or applicant in a consortium applying for Navigator funds will be looked at to determine the entity's type for purposes of meeting this requirement.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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	available in a given state since the applicant would meet the threshold of having at least two types of entities serving as a Navigator in the state?				
Eligible and Ineligible Applicants	**Q16:** What is the difference between a consortium partner and a subcontractor?	**A16:** A consortium partner must perform all required Navigator duties while a subcontractor can be used to only perform specific services. For example, a subcontract can be used for IT services associated with the applicant(s)' proposed program plans. Members of a consortium cannot be subcontracted.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q1:** Can my group/organization apply to be a Navigator grantee in more than one State/Service area?	**A1:** An applicant may propose to serve populations in both Federally-facilitated and State Partnership Marketplace service areas through the submission of one application, by submitting separate Budget Narratives requesting funding for each service area it proposes to serve. If the applicant intends to serve multiple States, a separate Budget Narrative should be submitted for each State; however, only one SF-424A may be submitted and should include the total funds requested for each line item category, as well as an overall total cooperative agreement request.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q2:** Can groups	**A2:** Small entities and individuals	FAQ April 9,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	apply together to receive grant funds or should we all apply separately?	proposing to serve smaller, hard-to-reach or underserved populations are encouraged to apply, particularly by partnering with other entities and/or individuals to form a consortium which serves a larger total portion of the population. In the case of an application from more than one entity or individual (i.e., a consortium), applicants must designate a lead applicant to serve as the primary contact.	2013		act-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q3:** If my group/organization applies, are we required to serve the entire state/service area?	**A3:** Applicants may explain in their applications that they expect to serve a specific population (geographic, ethnic, language, chronic condition) in a given state/service area. But if they receive an award, applicants must assist any consumer seeking assistance, even if that consumer is not a member of the group they stated they expect to serve in their funded proposal.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q4:** Can I/we propose to serve a specific population (geographic, ethnic, language, chronic condition) in a given state/service area?	**A4:** Yes, however, it is possible that multiple high ranking applications focusing on the same community within a State will not all be funded. Proposals that will increase the span of populations served by Navigators will be given priority. Applicants should demonstrate a general knowledge about the racial, ethnic, and cultural groups in their service area. As a reminder, if the applicant receives an award, applicants must assist any consumer seeking assistance, even if that consumer is not a	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		member of the group they stated they expect to serve in their funded proposal.			
Proposals	**Q5:** As a grantee, are we required to help anyone who comes to us for help, or can we assist only those consumers in the population we would like to target with our grant funds?	**A5:** Awardees will be required to assist any consumer seeking assistance, even if that consumer is not a member of the community(ies) or group the applicant stated they expect to serve, as outlined in their funded proposal. There may be some instances where a Navigator does not have the immediate capacity to help an individual, such as one who speaks a foreign language not spoken by the Navigator. In such cases, the Navigator should be capable of providing assistance in a timely manner but should also refer consumers seeking assistance to other Exchange resources, such as the toll-free Exchange Call Center, or to another Navigator in the same Exchange who might have better capacity to serve that individual more effectively. Additionally, if a Navigator is approached by a consumer who lives in a state with a Marketplace run by the state, or in a state in which the Navigator does not serve, the Navigator must refer the consumer to a Navigator in the consumer's state.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q6:** Is it possible for a State to be served wholly by Navigators who do not have a physical presence in the State?	**A6:** Although the FOA does not specifically require an individual or entity serving as a Navigator have a physical presence in the State they are serving, applicants must discuss in their application their existing relationships,	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		or how they could readily establish relationships with employers and employees, consumers (including uninsured and underinsured consumers), and/or self-employed individuals who are likely to be eligible for enrollment in a qualified health plan through the Marketplace in the applicant's proposed service area(s). In addition, applicants must provide a plan for conducting public education and outreach activities in their proposed service area.			
Proposals	**Q7:** Can an applicant use part of their Navigator funds to help bolster or support their state's Consumer Assistance Program (CAP)?	**A7:** No, Navigator funds may be used only for the activities listed in the FOA and in any future Notice of Award to a cooperative agreement recipient. Under the regulations governing the Navigator program, cooperative agreement funds may be used to make referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman programs established under Section 2793 of the Public Health Services Act, or any other appropriate State agency or agencies, but the regulation does not provide any authority to use cooperative agreement funds to or support those programs directly.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Proposals	**Q8:** How can I plan to help consumers if I am in a state that is not expanding	**A8:** Applicants should propose to serve the same population that they would if their state had expanded Medicaid and should be prepared to assist consumers of all income levels who may come to	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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	Medicaid in 2014?	them seeking assistance. Navigators should provide a "no wrong door" experience to consumers, creating as much of a start-to-finish process for consumers as possible whether they are eligible for a QHP, Medicaid, or CHIP.			
Proposals	**Q9:** How much time is it anticipated that it will take to assist a consumer with the enrollment process?	**A9:** The Paperwork Reduction Act (PRA) burden estimates (found here: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10463.html?DLPage=1&DLSort=1&DLSortDir=descending) provide for approximately 1 hour of time, on average, to be spent per consumer. This estimate includes not only completing the application, but would also encompass everything the consumer needs to do to get enrolled in coverage: explaining what information is needed to enroll, answering questions that may arise during the time they are completing the application for themselves and any family members, learning about different types of plan options and the Advanced Premium Tax Credit (APTC) available to them, and helping them select the plan that best meets their individual or family's needs. In instances where the consumer doesn't need as much help, for example just has a few questions, or is a single person applying for coverage, the amount of	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		time spent with the consumer will be less.			
Funding	**Q1:** Is the same amount of funds available in each Federally-facilitated or State Partnership service area?	**A1:** Each Federally-facilitated or State Partnership Marketplace service area will receive an apportionment of funds in the amounts listed in the FOA. To obtain the portion (in percent) of the eligible uninsured in a given Federally-facilitated or State Partnership Marketplace, the total number of uninsured (under age 65) legal residents in each State with a Federally-facilitated or State Partnership Marketplace was divided by the total number of uninsured legal residents among all States with a Federally-facilitated or State Partnership Marketplace. The funding amount available was then apportioned according to each Federally-facilitated or State Partnership Marketplace's portion of uninsured legal residents, with a minimum award	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		of $600,000 available per Federally-facilitated or State Partnership Marketplace service area. This created a percentage which was multiplied by the total amount of available Navigator cooperative agreement funding to generate the available funding threshold for each Federally-facilitated or State Partnership Marketplace service area. In cases where a Federally-facilitated or State Partnership Marketplace service area's apportionment was less than $600,000, funding was rounded up to $600,000 by proportionately reducing awards from Federally-facilitated or State Partnership Marketplace States with apportionments larger than $600,000.			
Funding	**Q2:** How much money should I/we apply for?	**A2:** The amount of funding awarded to a successful applicant within a Federally-facilitated or State Partnership Marketplace service area will be based on the scope and breadth of the activities being proposed and the size of the population to be served. For example, if an applicant in a given state/service area proposes to serve a small community in a remote area in that state/service area, with the goal of reaching 1,100 consumers, then the budget request must reflect an amount that is reasonable and appropriate with the activity (or activities) being proposed. The U.S. Department of Health & Human Services reserves the	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		right to reduce the budget requested based on its review of the proposed population and budget submitted by the applicant.			
Funding	**Q3:** How many awards will be made in each Federally-facilitated or State Partnership Marketplace service area?	**A3:** The total number of awards will depend upon the number of consumers each applicant proposes to serve. The total funding apportionment per each State with a Federally-facilitated or State Partnership Marketplace (see Section VIII. 3, State Reference List) is no less than $600,000.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Funding	**Q4:** When will award announcements be made?	**A4:** The anticipated award date is August 15, 2013.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Application Format and Submission	**Q1:** What is the deadline to submit my application?	**A1:** Applications are due June 7, 2013.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
	Q2: Can I submit my application via email?	**A2:** No, applications cannot be accepted through any email address. Full applications can only be accepted electronically through http://www.grants.gov. Full applications cannot be received via paper mail, courier, or delivery service, unless a waiver is granted per the instructions in the FOA included in Section IV. 1, Address to Request Application Package.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Application Format and Submission	**Q3:** Is there a specific format that my application must be submitted in?	**A3:** Yes, the FOA (See Section IV. 1, Address to Request Application Package, for more information) provides a list of all the information that must be	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		included in your application to ensure that it is reviewed by the objective review panel.			
Application Format and Submission	**Q4:** Can the workplan, timeline, and budget narrative be double spaced?	**A4:** These are considered part of the narrative portion of the application package and should be double spaced.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Application Format and Submission	**Q5:** If an applicant is proposing to serve multiple service areas, does the total allowable page limit for the budget narrative apply to each budget narrative submitted or is it 3 pages total?	**A5:** The page limit applies per budget narrative. For example, if an applicant is proposing to serve two service areas, they would submit two separate budget narratives of up to 3 pages each, for a total of 6 pages.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Application Review and Selection	**Q1:** What will the application review process entail?	**A1:** Applications will be reviewed by an objective review panel using an evaluation rubric developed by HHS and consisting of critical elements identified in Section V, Application Review Information, of the FOA. This evaluation rubric will be used by qualified, unbiased experts in their review of all applications. Applications will receive a "raw" score out of 100 points based on their ability to address the requirements of the FOA (See Section V. Application Review Information). The application will then be ranked through the use of statistical	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		techniques which negate to the extent possible any differences in scoring behaviors among different committees/panels.			
Application Review and Selection	**Q2:** Is there a minimum or maximum number of applications that will be funded in each Federally-facilitated or State Partnership service area?	**A2:** The regulation implementing the Affordable Care Act Section 1311(i), 45 155.210, requires that at least two types of entities serve as Navigators in each Exchange, and that at least one Navigator be a community and consumer- focused nonprofit. Other than meeting this requirement, there is no minimum or maximum number of applications that will be funded through this announcement.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Training and Certification	**Q1:** What will the training for Navigators look like and does everyone in a Navigator entity need to complete the training and certification process?	**A1:** Please see the Notice of Proposed Rulemaking for Navigator Standards we published on April 5, 2013 for a detailed discussion of our proposed training standards for Navigators in the Federally-facilitated and State Partnership Exchanges.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Training and Certification	**Q2:** Does the training and certification process need to be completed prior to beginning outreach and education activities?	**A2:** Please see the Notice of Proposed Rulemaking for Navigator Standards we published on April 5, 2013 for a detailed discussion of our proposed training standards for Navigators in the Federally-facilitated and State Partnership Exchanges.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Training and Certification	**Q3:** Will Navigator training be available for entities or individuals who are	**A3:** We anticipate that Navigator training would be available only to entities or individuals who are recipients of the cooperative agreements or	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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	not awarded a cooperative agreement?	employees or staff of those recipients hired to serve as Navigators. A similar training, however, will be made available for other in-person assistance opportunities.			
Training and Certification	**Q4:** How will privacy and security of consumer information be ensured?	**A4:** Navigators will receive extensive training on privacy and security and will be required to follow the standards issued by the Exchange pursuant to 45 C.F.R. §155.260.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Training and Certification	**Q5:** Will HHS provide us with training on the new health insurance marketplaces and newly available coverage options before we begin to help consumers?	**A5:** Yes, please see page 7 of the FOA. Navigators awarded cooperative agreements through this funding opportunity must complete a training program, including approximately 30 hours of an HHS-developed training, and pass an exam prior to beginning to help consumers. In addition, Navigators awarded through this funding opportunity will receive resources from HHS to complement the training program including a manual of standard operating procedures.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q1:** Is a letter of intent required?	**A1:** Applicants are strongly encouraged, but not required, to submit a non-binding Letter of Intent to Apply by May 1, 2013. The Letter of Intent should include the name of applicant(s), individuals, entities, or consortiums, and express intent to apply for a cooperative agreement award. Receipt of such letters enables HHS to better plan for the application review process. The signed	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		Letter of Intent to Apply must be submitted electronically in PDF format to navigatorgrants@cms.hhs.gov.			
Miscellaneous Questions	**Q2:** Will there be any technical assistance available prior to the application due dates?	**A2:** Yes, CMS will hold three pre-application conference calls for all potential applicants. **First call:** April 11, 2013 from 3:30 to 5:00 p.m. Eastern Daylight Time Toll-free teleconference phone number: 877-267-1577; ID: 5119 **Second call:** April 19, 2013 from 3:30 to 5:00 p.m. Eastern Daylight Time Toll-free teleconference phone number: 877-267-1577; ID: 2917 **Third call:** April 24, 2013 from 3:30 to 5:00pm Eastern Daylight Time Toll-free teleconference phone number: 877-267-1577; ID: 8100 For more information, See FOA Section III. 7, Pre-Application Conference Calls.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q3:** Are there any prohibitions on what I/we can use funds awarded under this FOA on?	**A3:** Yes, the FOA (See Section IV. 5, Funding Restrictions, for more information) provides a list of expenditures that award funds cannot be used to cover.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q4:** What is the	**A4:** The difference between grants and	FAQ April 9,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	difference between grants and cooperative agreements?	cooperative agreements is the degree of Federal programmatic involvement rather than the type of administrative requirements imposed. Therefore, statutes, regulations, policies, and the information contained in the HHS Grants Policy Statement that are applicable to grants also apply to cooperative agreements, unless the award itself provides otherwise	2013		act-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q5:** How do I know whether I am proposing to assist consumers in a Federally-facilitated or State Partnership Marketplace service area?	**A5:** Any State not running a certified State-based Marketplace for benefit year 2014 will have a Federally-facilitated or State Partnership Marketplace. To view a list of States that will have a Federally-facilitated or State Partnership Marketplaces in benefit year 2014 see FOA Section VIII. 3, State Reference List.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q6:** What is the length of the project period for this Cooperative Agreement?	**A6:** The project period is 12 months from the date of award.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q7:** What happens after the 12 month project period ends?	**A7:** The expectation is that there will be Navigator cooperative agreements awarded in the future, however, that is contingent on funding availability.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q8:** Can a Navigator grantee generate program income?	**A8:** Typically, a grantee can generate program income; however under this FOA, it will not be reasonable or allowable to generate program income. More information will be provided in the Terms and Conditions of award.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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Miscellaneous Questions	**Q9:** Do sub-recipients or sub-grantees need to have a DUNS and SAM number as well?	**A9:** All members of a group submitting an application must have a DUNS number, however, only the primary grantee must maintain a current registration in the SAM database. SAM registration is required to be able to submit an application and should be done a minimum of 5 business days in advance of the application submission deadline. Subawards may only be made to entities that have a DUNS number.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q10:** What is the difference between enrolling individuals into qualified health plans (QHPs) and facilitating their enrollment into QHPs?	**A10:** Enrollment and determinations of eligibility are responsibilities of the Marketplace and will be carried out by the Marketplace, or in certain cases, by agents and brokers. See 45 C.F.R. §§ 155.400(a), 155.220, and 155.310(d). Navigators facilitate consumers' enrollment into QHPs by providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application, clarifying the distinctions among QHPs, and making informed decisions during the health plan selection process.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html
Miscellaneous Questions	**Q11:** How do I apply to be Navigator?	**A11:** Thank you for your inquiry about the Navigator program in Federally-facilitated Marketplaces. The funding opportunity announcement can be found on www.grants.gov by searching for CFDA number 93.750. Additional information about the funding opportunity can be found here: http://www.cms.gov/cciio/resources/fact	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/navigator-foa-faq.html

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		sheets/navigator-foa.html.			
Navigator FOA Application Overview	**Q1:** Where can I access application materials?	**A1:** Application materials are available for download at http://www.grants.gov. The Centers for Medicare & Medicaid (CMS) requires applications for all announcements to be submitted electronically through http://www.grants.gov. For assistance with http://www.grants.gov, contact support@grants.gov or 1-800-518-4726. At http://www.grants.gov, applicants will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf
Navigator FOA Application Overview	**Q2:** Is there assistance available if I experience technical challenges while submitting an application?	**A2:** Yes. Applicants can contact Grants.gov Support directly at http://www.grants.gov/customersupport or 1-800-518-4726. Customer Support is available to address questions 24 hours a day, 7 days a week except on Federal holidays. Upon contacting Grants.gov, obtain a tracking number as proof of contact. The tracking number is helpful if there are technical issues that cannot be resolved and a waiver from the agency must be obtained. If it is determined that a waiver is needed, an applicant must submit a request in writing (emails are acceptable) to Michelle.Feagins@cms.hhs.gov with a clear justification for the need to deviate from the standard electronic submission process. If the waiver is approved, the	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf

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		application should be sent directly to Michelle Feagins in the Division of Grants Management, and received by the application due date.			
Navigator FOA Application Overview	**Q3:** What are some of the key actions I need to complete prior to submitting an application for this funding opportunity?	**A3: Employer Identification Number** All applicants, to include individuals who are self-employed, must have a valid Employer Identification Number (EIN), otherwise known as a Taxpayer Identification Number (TIN) assigned by the Internal Revenue Service to apply. Applicants should begin the process of obtaining an EIN/TIN upon posting of the FOA to ensure this information is received in advance of application deadlines. Applicants can submit an electronic request for an EIN at http://www.irs.gov by entering "EIN" in the search box. **Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS number)** All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number in order to apply. The DUNS number is a nine-digit identification number that uniquely identifies business entities. Applicants can obtain a DUNS number at http://www.dunandbradstreet.com or by calling 1-866-705-5711. Applicants should obtain this DUNS number as soon as possible upon posting	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf

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		of the FOA to ensure all registration steps are completed in time. See FOA Section IV. 1, Address to Request Application Package, for more information on obtaining a DUNS number. **System for Award Management (SAM)** All applicants must register in the SAM database (https://www.sam.gov/) in order to be able to submit an application the SAM registration process is a separate process from submitting an application. Applicants should allow a minimum of five business days to complete SAM registration; however, in some cases, the registration process can take approximately two weeks or longer to be completed. Therefore, applicants should begin the SAM registration process upon posting of the FOA to ensure that it does not impair their ability to meet required submission deadlines. In order to register, applicants must provide their DUNS and EIN numbers. Each year organizations and entities registered to apply for Federal grants through http://www.grants.gov must renew their registration with the SAM. Failure to renew SAM registration prior to application submission will			

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		prevent an applicant from successfully applying via Grants.gov. Similarly, failure to maintain an active SAM registration during the application review process can prevent HHS from issuing your agency an award under this program. Additional information about SAM is available at https://www.sam.gov/portal/public/SAM/ and in the FOA in Section III. 1, Eligible Applicants.			
Navigator FOA Application Overview	**Q4: What instructions should I follow for submitting an application via http://www.grants.gov?**	**A4:** Applicants may access the electronic application for this project at http://www.grants.gov by searching the downloadable application page by the CFDA number 93.750. An Authorized Organizational Representative (AOR) is the individual who will officially submit an application on behalf of the organization and he or she must register with Grants.gov for a username and password. AORs must complete a profile with Grants.gov using their organization's DUNS Number to obtain their username and password at http://grants.gov/applicants/get_registered.jsp. AORs must wait one business day after successful registration in SAM before entering their profiles in Grants.gov. Applicants should complete this process	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf

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		as soon as possible after successful registration in SAM to ensure this step is completed in time to apply before application deadlines. When an AOR registers with Grants.gov to submit applications on behalf of an organization, that organization's E-Biz point of contact will receive an email notification. The email address provided in the profile will be the email used to send the notification from Grants.gov to the E-Biz POC with the AOR copied on the correspondence. The E-Biz POC must then login to Grants.gov (using the organization's DUNS number for the username and the special password called "M-PIN") and approve the AOR, thereby providing permission to submit applications.			
Navigator FOA Application Overview	**Q5:** Are there restrictions on the type of files submitted with my application?	**A5:** Yes. Any files uploaded or attached to the Grants.Gov application must be PDF file format and must contain a valid file format extension in the filename. Even though Grants.gov allows applicants to attach any file formats as part of their application, CMS restricts this practice and only accepts PDF file formats. Any file submitted as part of the Grants.gov application that is not in a PDF file format, or contains password protection, will not be accepted for processing and will be excluded from the application during the review process. In addition, the use of compressed file formats such	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf

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		as ZIP, RAR, or Adobe Portfolio will not be accepted. It is recommended that scanned copies not be submitted through Grants.gov unless the applicant confirms the clarity of the documents. All documents that do not conform to the above specifications will be excluded from the application materials during the review process.			
Navigator FOA Application Overview	**Q6:** Can I submit my application by email or via paper mail?	**A6:** Applications cannot be accepted through any email address. Applications cannot be accepted via paper mail, courier, or delivery service, unless a waiver is granted per the instructions noted in the FOA in Section IV. 1, Address to Request Application Package. The applicant must seek a waiver at least ten days prior to the application deadline if the applicant wishes to submit a paper application.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf
Navigator FOA Application Overview	**Q7:** Are there any standard forms I need to complete?	**A7:** Yes. The standard forms below must be completed with an electronic signature and enclosed as part of the application. See Section IV. 1, Address to Request Application of the FAO for more information. ☐ SF-424: Official Application for Federal Assistance ☐ SF-424A: Budget Information Non-Construction ☐ SF-424B: Assurances-Non-Construction Programs ☐ SF-LLL: Disclosure of Lobbying Activities	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf

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Navigator FOA Application Overview	**Q8:** Is there anyone I can contact if I have a programmatic or administrative question?	**A8:** Yes. For programmatic questions about the Cooperative Agreement to Support Navigators in Federally-facilitated and State Partnership Marketplace, please email: navigatorgrants@cms.hhs.gov.	FAQ April 9, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/navigator-foa-application-overview-4-9-2013.pdf
Essential Health Benefits Bulletin	**Q1:** Under the approach described in the Bulletin, would the Secretary permit the State to adopt different benchmark plans for its individual and small group markets?	**A1:** No. 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.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q2:** When a State chooses an EHB benchmark plan, would the benefits be frozen in time, or as the benchmark plan updates benefits each year, would the benchmark plan reflect these updates?	**A2:** As indicated in the Bulletin, we intend to propose a process for updating EHB in future rulemaking. Under the intended approach, the specific set of benchmark benefits selected in 2012 would apply for plan years 2014 and 2015. For 2014 and 2015, the EHB benchmark plan selection would take place in the third quarter of 2012. A consistent set of benefits across these two years would limit market disruption during this transition period. As	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		indicated in the Bulletin, HHS intends to revisit this approach for plan years starting in 2016.			
Essential Health Benefits Bulletin	**Q3:** Would States be required to defray the cost of any State-mandated benefit?	**A3:** The Affordable Care Act requires States to defray the costs of State-mandated benefits in qualified health plans (QHPs) that are in excess of the EHB. If a State were to choose a benchmark plan that does not include all State-mandated benefits, the Affordable Care Act would require the State to defray the cost of those mandated benefits in excess of EHB as defined by the selected benchmark. States have several benchmark options from which to choose, including the largest small group market plan in the State, which is the default benchmark plan for each State. Generally, insured plans sold in the small group market must comply with State mandates to cover benefits. Thus, if a small group market benchmark plan was selected, these mandated benefits would be part of the State-selected EHB. However, if there are State mandates that do not apply to the small group market, such as mandates that apply only to the individual market or to HMOs, the State would need to defray the costs of those mandates if the mandated benefits were not covered by the selected benchmark. As indicated in the Bulletin, the treatment of State benefit mandates is intended as a two-year transitional	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		policy that HHS intends to revisit for plan years starting in 2016.			
Essential Health Benefits Bulletin	**Q4:** Could a State add State-mandated benefits to the State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits?	**A4:** No. We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan. As mentioned above, HHS intends to revisit this approach for plan years starting in 2016.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q5:** How must a State supplement a benchmark plan if it is missing coverage in one or more of the ten statutory categories?	**A5:** We intend to propose that if a benchmark plan is missing coverage in one or more of the ten statutory categories, the State must supplement the benchmark by reference to another benchmark plan that includes coverage of services in the missing category, as described in the Bulletin. For example, if a benchmark plan covers newborn care but not maternity services, the State must supplement the benchmark to ensure coverage for maternity services. The default benchmark plan would be supplemented by looking first to the second largest small group market benchmark plan, then to the third, and then, if neither of those alternative small group market benchmark plans offers benefits in a missing category, to the	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		FEHBP benchmark plan with the highest enrollment. Our research found that three categories of benefits - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans. Thus, the Bulletin describes special rules to ensure meaningful benefits in those categories: • As a transitional approach for habilitative services, the Bulletin discusses two alternative options that we are considering proposing: o A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity. o A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future. Under either approach, a plan would be required to offer at least some habilitative benefit. • For pediatric oral care, we are considering proposing that the State would supplement the benchmark plan with benefits from either: o The Federal Employees Dental and Vision Insurance Program (FEDVIP) dental plan with the largest national enrollment; or o The State's separate Children's Health Insurance Program (CHIP). • For pediatric vision care, we are			

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		considering proposing that the State would supplement the benchmark plan with the benefits covered in the FEDVIP vision plan with the highest enrollment.			
Essential Health Benefits Bulletin	**Q6:** One of the currently intended benchmark plans is the largest plan by enrollment in any of the three largest products in the small group market. What is the difference between a plan and a product?	**A6:** For the purpose of administering the health plan finder on HealthCare.gov, HHS has defined "health insurance product" (product) as a package of benefits an issuer offers that is reported to State regulators in an insurance filing. Generally, this filing describes a set of benefits and often a provider network, but does not describe the manner in which benefits may be tailored, such as through the addition of riders. For purposes of identifying the benchmark plan, we identify the plan as the benefits covered by the product excluding all riders. HHS intends to propose that if benefits in a statutory category are offered only through the purchase of riders in a benchmark plan, that required EHB category would need to be supplemented by reference to another benchmark as described in question 5.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q7:** What is the minimum set of benefits a plan must offer in a statutory category to be considered to offer coverage within the	**A7:** Under the approach described in the Bulletin, a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR 457.431,	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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	category consistent with the benchmark plan?	and provided that substitutions would not violate other statutory provisions. For example, a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence and the other criteria are met. The benchmark plan would provide States and issuers with a frame of reference for the EHB categories.			
Essential Health Benefits Bulletin	**Q8:** Can scope and duration limitations be included in the EHB?	**A8:** Yes. Under the intended approach, a plan must be substantially equal to the benchmark plan, in both the scope of benefits offered and any limitations on those benefits such as visit limits. However, any scope and duration limitations in a plan would be subject to review pursuant to statutory prohibitions on discrimination in benefit design. In addition, the Public Health Service Act (PHS Act) section 2711, as added by the Affordable Care Act, prohibits imposing annual and lifetime dollar limits on EHB. Note that for annual dollar limits, the prohibition generally applies in full starting in 2014, with certain restricted annual limits permitted until that time. The prohibition on annual dollar limits does not apply to grandfathered individual market policies.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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Essential Health Benefits Bulletin	**Q9:** State-mandated benefits sometimes have dollar limits. How does the intended EHB policy interact with the annual and lifetime dollar limit provisions of the Affordable Care Act?	**A9:** PHS Act section 2711, as added by the Affordable Care Act, does not permit annual or lifetime dollar limits on EHB. Therefore, if a benefit, including a State-mandated benefit, included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition without the dollar limit. However, based on the Bulletin describing our intended approach, plans would be permitted to make actuarially equivalent substitutions within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q10:** How would the intended EHB policy affect self-insured group health plans, grandfathered group health plans, and the large group market health plans? How would employers sponsoring such plans determine which benefits are EHB when they offer coverage to employees residing in more than one	**A10:** Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB. However, the prohibition in PHS Act section 2711 on imposing annual and lifetime dollar limits on EHB does apply to self-insured group health plans, large group market health plans, and grandfathered group market health plans. These plans are permitted to impose non-dollar limits, consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions. In addition, these plans can continue to	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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	State?	impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB. To determine which benefits are EHB for purposes of complying with PHS Act section 2711, the Departments of Labor, Treasury, and HHS will consider a self-insured group health plan, a large group market health plan, or a grandfathered group health plan to have used a permissible definition of EHB under section 1302(b) of the Affordable Care Act if the definition is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories). Furthermore, the Departments intend to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB.			
Essential Health Benefits Bulletin	**Q11:** In the case of a non-grandfathered insured small group market plan that offers coverage to employees residing in more than one State, which State-selected EHB benchmark plan would apply?	**A11:** Generally, the current practice in the group health insurance market is for the health insurance policy to be issued where the employer's primary place of business is located. As such, the employer's health insurance policy must conform to the benefits required in the employer's State, given that the employer is the policyholder. Nothing in the Bulletin or our proposed approach seeks to change this	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		current practice. Therefore, the applicable EHB benchmark for the State in which the insurance policy is issued would determine the EHB for all participants, regardless of the employee's State of residence. Health insurance coverage not required to offer EHB, including grandfathered health plans and large group market coverage, would comply with the applicable annual and lifetime limits rule, as described in the answer to the previous question.			
Essential Health Benefits Bulletin	**Q12:** How do the requirements regarding coverage of certain preventive health services under section 2713 of the PHS Act interact with the intended EHB policy?	**A12:** The preventive services described in section 2713 of the PHS Act, as added by section 1001 of the Affordable Care Act, will be a part of EHB.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q13:** Under the intended EHB approach, would the parity requirements in MHPAEA be required in EHB?	**A13:** Yes. Consistent with Congressional intent, we intend to propose that the parity requirements apply in the context of EHB.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q14:** Could a State legislature require that issuers offer a unique set of "EHB" the way Medicaid and CHIP	**A14:** No. Under the approach we intend to propose, States would be required to adhere to the guidelines for selecting a benchmark plan outlined in the Bulletin. Otherwise, EHB in that State would be defined by the default benchmark plan.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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	benchmarks have options for Secretary-approved benefits, or benchmark equivalent benefits, if the State benefits are actuarially equivalent to one of the choices that HHS defines to be EHB?				
Essential Health Benefits Bulletin	**Q15:** Would States need to identify the benchmark options themselves?	**A15:** HHS plans to report the top three FEHBP benchmark plans to States based on information from the Office of Personal Management. HHS also plans to provide States with a list of the top three small group market products in each State based on data from HealthCare.gov from the first quarter of the 2012 calendar year. We intend to continue working with States to reconcile discrepancies in small group market product enrollment data. If a State chooses to consider State employee plans and/or the largest commercial HMO benchmark plans, the State would be required to identify benchmark options for those benchmark plans, as is done today in Medicaid and CHIP.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q16:** When would States be required to select a benchmark plan?	**A16:** As noted in the Bulletin, we intend to propose that States must select an EHB benchmark plan in the third quarter two years prior to the coverage	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		year, based on enrollment from the first quarter of that year. Thus, HHS anticipates that selection of the benchmark plan for 2014 and 2015 would need to take place in the third quarter of 2012 in order to provide each State's EHB package, which includes the benchmark plan, any State-supplemented benefits to ensure coverage in all statutory categories, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011. This schedule would ensure plans have time to determine benefit offerings before QHP applications are due. Separate guidance on the selection of Medicaid benchmark plans is forthcoming.			
Essential Health Benefits Bulletin	**Q17:** How would a State officially designate and communicate its choice of benchmark plan and the corresponding benefits to HHS?	**A17:** HHS is currently evaluating options for collecting a State's benchmark plan selection and benefit information. A State's EHB package would include the benefits offered in the benchmark plan, any supplemental benefits required to ensure coverage within all ten statutory categories of benefits, and any adjustments to include coverage for applicable State mandates enacted before December 31, 2011. HHS anticipates that submissions will be collected from States in a standardized format that includes the name of the benchmark plan along with benefit information and, if necessary,	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		the benefits used to ensure coverage within a missing statutory category.			
Essential Health Benefits Bulletin	**Q18:** How can my State find benefit information with respect to the default benchmark plan?	**A18:** As indicated in the Bulletin, we intend to propose that the default benchmark plan in each State would be the largest small group market product in the State's small group market. HHS anticipates that it will identify and provide benefit information with respect to State-specific default benchmark plans in the Fall of 2012.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q19:** By empowering the State to select an EHB benchmark plan, does HHS intend that the State executive branch (i.e., State Insurance Department) or the legislative branch must make the selection?	**A19:** Each State would be permitted to select a benchmark plan from the options provided by HHS by whatever process and through whatever State entity is appropriate under State law. In general, we expect that the State executive branch would have the authority to select the benchmark plan. It is also possible that, in some States, legislation would be necessary for benchmark plan selection. It is important to note that, regardless of the entity making these State selections, it is the State Medicaid Agency that will be held responsible for the implementation of EHB through the Medicaid benchmark coverage option.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q20:** How would EHB be defined for Medicaid benchmark or benchmark-equivalent plans?	**A20:** Since 2006, State Medicaid programs have had the option to provide certain groups of Medicaid enrollees with an alternative benefit package known as "benchmark" or "benchmark-equivalent" coverage, based on one of	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf

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		three commercial insurance products, or a fourth, "Secretary-approved" coverage option. Beginning January 1, 2014, all Medicaid benchmark and benchmark equivalent plans must include at least the ten statutory categories of EHBs. Under the Affordable Care Act, the medical assistance provided to the expansion population of adults who become eligible for Medicaid as of January 1, 2014, will be a benefit package consistent with section 1937ii benchmark authority. For Medicaid benchmark and benchmark equivalent plans, three of the benchmark plans described in section 1937 (the State's largest non-Medicaid HMO, the State's employee health plan, and the FEHBP BCBS plan) may be designated by the Secretary as EHB benchmark plans, as described in the EHB Bulletin. A State Medicaid Agency could select any of these section 1937 benchmark plans as its EHB benchmark reference plan for Medicaid. There would be no default EHB benchmark reference plan for purposes of Medicaid; each State Medicaid Agency would be required to identify an EHB benchmark reference plan for purposes of Medicaid as part of its 2014-related Medicaid State Plan changes. If the EHB benchmark plan selected for Medicaid were to lack coverage within			

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		one or more of the ten statutorily-required categories of benefits, the EHB benchmark plan (and therefore the section 1937 benchmark plan) would need to be supplemented to ensure that it provides coverage in each of the ten statutory benefit categories. This would be in addition to any other requirements for Section 1937 plan, including Mental Health Parity and Addition Equity Act compliance.			
Essential Health Benefits Bulletin	**Q21:** Could a State select a different EHB benchmark reference plan for its Medicaid section 1937 benchmark and benchmark equivalent plans than the EHB reference plan it selects for the individual and small group market?	**A21:** Yes. Under our intended proposal, a State would not be required to select the same EHB benchmark reference plan for Medicaid section 1937 plans that it selects for the individual and small group market, and it could have more than one EHB benchmark reference plan for Medicaid, for example, if the State were to develop more than one benefit plan under section 1937.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
Essential Health Benefits Bulletin	**Q22:** Could a State select its regular Medicaid benefit plan as its Section 1937 benchmark coverage package?	**A22:** Yes. A State could propose its traditional Medicaid benefit package as a section 1937 benchmark plan under the Secretary-approved option available under section 1937 of the Social Security Act. The State would have to ensure, either through that benefit plan or as a supplement to that plan, that the ten statutory categories of EHB are covered.	FAQ February 17, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf
State evaluation of plan	**Q1:** Can a state	**A1:** Yes. An interested State should	FAQ February	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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management activities of health plans and issuers	evaluate whether health plans and issuers meet certification standards and conduct other specified plan management activities as a part of its established regulatory role and in connection with market reform standards without submitting a Blueprint?	submit to HHS a letter as soon as possible from its Governor or Commissioner of Insurance attesting that the State will perform all the plan management activities listed in Section 4.0 of the Blueprint in time for the 2013 QHP selection process. This letter also should include specific attestations that the State will: (1) have the legal authority and operational capacity to conduct the plan management activities required to support certification of QHPs, as described in 45 CFR 155.l0l0(a); (2) collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020; (3) help ensure ongoing plan compliance and resolve consumer complaints described in 45 CFR 155.1010(a)(2); (4) provide issuer technical assistance as needed; (5) help manage decertification of issuers and associated appeals in compliance with 45 CFR 155.1080; and (6) participate in a one-day review of its operational plans and capacity to perform these functions. After receiving this letter and completing a review, HHS will initiate a process under which it may rely on the state's recommendations that health plans meet QHP certification requirements. This process would likely involve a written understanding between the state and HHS, in addition to any Agreement	20, 2013		iles/Downloads/plan-management-faq-2-20-2013.pdf

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		under which § 1311(a) grant funds are provided. Assuming a state continues to act in accordance with its attestations, HHS would continue to rely on its recommendations with regards to Exchange specific requirements for QHPs, for example, anti-discrimination and network adequacy. HHS will maintain its responsibility for ensuring that QHPs meet all QHP certification standards. Finally, a state is eligible to apply for an Exchange Establishment Grant, consistent with the guidance set forth in the Funding Opportunity Announcement, to fund these activities. If a state does apply, it is agreeing to participate in the review, reporting, and technical assistance programs associated with oversight of these Establishment Grants and to ensure appropriate use of grant funds and effective performance of the required plan management activities			
Exchange Establishment Cooperative Agreement Funding	**Q1:** In the new funding opportunity announcement (FOA), released in June 29, 2012, States may be awarded establishment grants through December 2014. Does this change the deadlines for State Exchange approval?	**A1:** No. The new FOA does not change the deadlines for State Exchange approval, which are set forth in the Affordable Care Act and regulations.	FAQ June 29, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-est-grant-faq-06292012.html

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Exchange Establishment Cooperative Agreement Funding	**Q2:** How many opportunities remain for States to apply for funding?	**A2:** Ten additional opportunities for States to apply for Level One and/or Level Two funding were announced under the new funding opportunity announcement, with all awards made by December 31, 2014. In addition to the final funding opportunity under the old FOA, HHS anticipates Level One Establishment and Level Two Establishment applications will be due: August 15, 2012; November 15, 2012; February 15, 2013; May 15, 2013; August 15, 2013; November 15, 2013; February 14, 2014; May 15, 2014; August 15, 2014; and October 15, 2014. HHS anticipates making Notices of Grant Award approximately 45 days after application due dates. Note: On November 30, 2012, an additional application deadline of December 28, 2012 was added for States to apply for Exchange Establishment Funding. Level One and Level Two Exchange Establishment Application Due Dates: December 28, 2012; February 15, 2013; May 15, 2013; August 15, 2013; November 15, 2013; February 14, 2014; May 15, 2014; August 15, 2014; October 15, 2014	FAQ June 29, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-est-grant-faq-06292012.html
Exchange Establishment	**Q3:** What Exchange	**A3:** The Affordable Care Act provides	FAQ June 29,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Cooperative Agreement Funding	costs can be covered by 1311 grant funding?	the Secretary authority to provide §1311(a) grant funds for State activities related to establishment of an Exchange, including establishment of a State-based Exchange, development of functionalities that allow the State to participate in a State Partnership Exchange, and State activities to establish interfaces with the Federally-facilitated Exchange. These costs are outlined in the new FOA as well as in prior FOAs. The first year of Exchange activity is critical to ensuring Exchange self-sufficiency. The establishment of an Exchange and activities related to such establishment also include start-up year expenses to allow consumer outreach, testing and necessary improvements during the initial start-up year. For example, in the start-up year, we anticipate significant resources will be committed to enhancing systems, developing protocols, raising consumer awareness, training staff, and strengthening the overall effectiveness of operations. Thus, the Secretary has determined that §1311(a) grant funds are available to fully fund Exchange-related expenses (in the State's approved work plan and budget) until: 1) the end of the start-up year that coverage is provided through the Exchange, 2) the time a State-based	2012		act-Sheets-and-FAQs/hie-est-grant-faq-06292012.html

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		Exchange becomes self-sufficient, or 3) §1311(a) grant funds have been expended, whichever comes first. Similarly, a Partnership Exchange State may receive funding for its start-up year expenses supporting the FFE in a Partnership model, as well costs associated with transition to and establishment of a State-based Exchange. These funds are available to cover the costs of approved start-up year expenses or State activities in a State-based or State Partnership Exchange, consistent with the terms and conditions of the grant award and the expiration of the project period. States participating in the Federally-facilitated Exchanges may also receive funding to support a transition to a Partnership Exchange or State-based Exchange. These FAQs apply to awards under this FOA and any grants awarded under prior FOAs (Exchange Establishment Cooperative Agreement Funding). Please note that HHS will not grant new awards after December 31, 2014. Per standard grants management policy, CMS will review project plans to avoid duplicative funding of expenses involved in any transition.			
Exchange Establishment Cooperative Agreement Funding	**Q4:** What is the last day that a State can spend its award?	**A4:** Grantees are encouraged to drawdown funding within their budget period (up to one year for Level One	FAQ June 29, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/hie-est-grant-faq-06292012.html

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		and up to three years for Level Two grants); however, at the recommendation of CCIIO's State Officer and at the discretion of the Grant Management Officer, grantees may receive a no-cost extension that will allow them to spend funding up to the expiration date of the project period. At HHS's discretion, a project period can be extended for a maximum of five years past the date of the award. Note, however, that all spending of §1311(a) funds awarded under a cooperative agreement must be consistent with the scope of the statute, FOA, and terms and conditions of the awarded cooperative agreement.			
Exchange Establishment Cooperative Agreement Funding	**Q1:** What is this funding opportunity?	**A1:** This Funding Opportunity provides States, the District of Columbia, and consortia of States, with financial assistance for the establishment of Exchanges. Grant Awards made under this FOA will provide funds for States to complete activities for achieving approval in accordance with§ 1321 of the Affordable Care Act and the requirements established through the rulemaking process (45 C.F.R. § 155.105 (77 Fed. Reg. at 18446)). Funds may be awarded through the end of 2014 to support State activities to establish a State-based Exchange, interface with the Federally-facilitated Exchange, or to develop activities under the State Partnership Exchange Plan	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		Management and/or Consumer Assistance model. (Please refer to Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchange and General Guidance on Federally-Facilitated Exchanges available at http://cms.gov/cciio/ for information on the Exchange models.)			
Exchange Establishment Cooperative Agreement Funding	**Q2:** What grants are available through this announcement?	**A2:** States may choose whether to apply for Level One Exchange Establishment or Level Two Exchange Establishment grants. Level One Exchange Establishment. These grants provide up to one year of funding to States that are interested in undertaking specific activities in establishment of a State-based Exchange, a Federally-facilitated Exchange, or State Partnership Exchange. The Level One Establishment grants are open to all States and States can apply for additional years of funding. Level Two Exchange Establishment. These grants provide up to three years of funding to States that are establishing a State-based Exchange and can demonstrate capacity to establish the full set of core Exchange activities. States must meet specific eligibility criteria, including legal authority to establish and operate an Exchange that	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		complies with Federal requirements available at the time of the application, governance structure for the Exchange, and an initial plan discussing long-term operational costs of the Exchange. States may only receive one Level Two Exchange Establishment grant.			
Exchange Establishment Cooperative Agreement Funding	**Q3:** Can a State apply for a Level One Exchange Establishment grant after receiving a Level Two Exchange Establishment grant?	**A3:** Yes. States that have previously received a Level Two Exchange Establishment Cooperative Agreement may apply for additional funds as a Level One applicant; however, the scope of the application must be limited to activities not within the scope of the prior Level Two Cooperative Agreement.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q4:** If a State initially applied for funding for a State-based Exchange, can that State transition to another Exchange model?	**A4:** Yes. This funding opportunity allows States the flexibility to transition between Exchange models over time. For example, a State might choose to operate within the Federally-facilitated Exchange in 2013-14, as a Plan Management Partner in the Federally-facilitated Exchange in 2014-15, and, finally, as an approved State-based Exchange in 2015-forward.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q5:** Through the June 2012 FOA, States may be awarded Establishment grants through December 2014. Does this mean my State's Exchange	**A5:** No. This FOA does not change the deadlines for Exchange approval or operation set forth in the Affordable Care Act and regulations.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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	does not have to be approved until December 2014?				
Exchange Establishment Cooperative Agreement Funding	**Q6:** Who is eligible to apply for this FOA?	**A6:** This funding opportunity is open to States, consortia of States, and the District of Columbia. The Governor (the Mayor, if from the District of Columbia) may designate a governmental agency or quasi-governmental entity to apply for grants on behalf of that State. Exchanges that have been established by the State as non-profits are eligible to apply for funding if designated as the applicant entity by the State due to their quasi-governmental nature.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q7:** What are the due dates for this FOA?	**A7:** All grant applications must be submitted electronically and be received through http://www.grants.gov - Opens in a new window by 11:59 pm Eastern Time on the respective due dates below: Level One Exchange Establishment Application Due Dates: August 15, 2012; November 15, 2012; February 15, 2013; May 15, 2013; August 15, 2013; November 15, 2013; February 14, 2014; May 15, 2014; August 15, 2014; October 15, 2014 Level Two Exchange Establishment Application Due Dates: August 15, 2012; November 15, 2012; February 15,	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		2013; May 15, 2013; August 15, 2013; November 15, 2013; February 14, 2014; May 15, 2014; August 15, 2014; October 15, 2014 Note: On November 30, 2012, an additional application deadline of December 28, 2012 was added for States to apply for Exchange Establishment Funding. Level One and Level Two Exchange Establishment Application Due Dates: December 28, 2012; February 15, 2013; May 15, 2013; August 15, 2013; November 15, 2013; February 14, 2014; May 15, 2014; August 15, 2014; October 15, 2014			
Exchange Establishment Cooperative Agreement Funding	**Q8:** What are the potential award dates for under this FOA?	**A8:** The anticipated award date for both Level One Exchange Establishment and Level Two Exchange Establishment awards is approximately 45 business days after each application due date.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q9:** What is the period of performance for awards made under this FOA?	**A9:** The project period for each award will vary based on when a State is awarded an Exchange Establishment Cooperative Agreement. Level One Exchange Establishment awards will be for up to one year after the date of award. Level Two Exchange Establishment awards will be for up to three years after the date of award.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement	**Q10:** What level of funding is available	**A10:** Funds are available to support grants as necessary to fulfill the purpose	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-

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Funding	under this FOA?	of this funding opportunity to the fifty States, District of Columbia, and/or consortia of States. The award amount will vary based on application category and the specific needs of each State.			establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q11:** Will HHS provide any guidance or assistance on completing the application process?	**A11:** HHS will hold pre-application conference calls for potential applicants. The conference calls will provide an overview of this project and budget guidance; review the instruction provided by this Funding Opportunity Announcement and other available materials; and will include an opportunity for States to ask questions. A schedule of pre-application calls will be on the CCIIO website: http://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Planning and Establishment Grants.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q12:** How do I download and submit the application?	**A12:** You can access the electronic application for this project on http://www.grants.gov - Opens in a new window . You must search the downloadable application page by the CFDA number (93.525). On the Grants.gov website, you also will find information about submitting an application electronically through the site.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q13:** Should the documents that are submitted as attachments to the	**A13:** Grants.gov and the awarding agency will accept Word or PDF attachments. However, if an applicant submits an attachment in Word and	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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	grant application be in PDF or Word format?	receive an error message regarding the attachment, the applicant should convert the Word attachment into a PDF attachment and then resubmit the application. Note: Grants.gov requires each attached file to have a unique file name.			
Exchange Establishment Cooperative Agreement Funding	**Q14:** What if a State has an ongoing issue with obtaining the Central Contractor Registry (CCR) number or the correct Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number?	**A14:** If a State has ongoing issues with obtaining a CCR or DUNS number, it must receive a case number from the respective system. The State should then inform the awarding agency of the delay and provide the case number.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q15:** Who are the points of contact for questions related to these grants?	**A15:** For questions about the grant announcement, please contact: Michelle Feagins Office of Acquisition and Grants Management Department of Health and Human Services (301) 492-4312 Michelle.Feagins@hhs.gov For questions about programmatic issues related to the grant, please contact: Katherine Bryant Center for Consumer Information and	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		Insurance Oversight Centers for Medicare & Medicaid Services Department of Health and Human Services (301) 492-4446 Katherine.Bryant@cms.hhs.gov			
Exchange Establishment Cooperative Agreement Funding	**Q16:** Can a State be reimbursed for pre-award costs under this FOA? For example, if a State is ready now to begin activities related to the Exchanges and it does not want to delay planning and other activities until it receives grant funding, can the State charge to future grants the costs it is incurring now?	**A16:** The State may seek reimbursement for pre-award costs provided that the costs are allowable costs incurred up to 90 days before grant award that cannot be covered under existing funding. Written approval must be provided by HHS and the budget narrative and work plan should clearly identify the funds that were spent prior to the project period.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q17:** Is it permissible to use the grant funds for State travel costs to Federally-sponsored meetings related to the grants?	**A17:** Yes, the grant funds can be used for State travel costs to Federally-sponsored meetings related to the grants. To the extent possible, these costs are to be outlined in the budget narrative.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q18:** May these grant funds be used primarily to hire personnel?	**A18:** These grant funds must be used for activities related to establishing Exchanges. The proportion of grant funds used to hire or contract with	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		personnel for these activities will depend on the needs of the grant applicant.			
Exchange Establishment Cooperative Agreement Funding	**Q19:** Can a state that wants to be a Consumer Assistance State Partner, but also wants to do state-specific outreach and education, apply for Exchange Establishment grant funding to cover those costs?	**A19:** Yes, CMS envisions a collaborative model around consumer outreach and education in the Consumer Assistance Partnership. All Exchanges will provide consumer assistance, outreach, and education. We encourage states involvement in these activities even if the state is not directly operating a State-based Exchange. States can apply for §1311(a) grant funding to support its work in collaborating with CMS to perform these activities in connection with its Exchange.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q20:** The FOA requires applicants to provide documents confirming actual or pending agreements with subcontractors. How does a State identify subcontractors in its proposal if it doesn't know who it will be subcontracting with due to State procurement requirements?	**A20:** If a State cannot name specific subcontractors, it should indicate this in the proposal and identify the tasks a subcontractor may perform.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q21:** Can a State contract out a majority of the work	**A21:** Yes. The State remains responsible for ensuring that all subcontractors comply with the terms	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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	associated with the grant?	and conditions of the grant.			
Exchange Establishment Cooperative Agreement Funding	**Q22:** May a State amend its grant proposal?	**A22:** Yes. A State grantee may request changes to a grant award. If a grantee would like to make a substantive amendment to its grant award after the project year has begun, that change will be considered a Change in Scope and must be approved by CCIIO. A request for approval of the Change in Scope must be submitted to the Program Official. Only after the Change in Scope is approved by CCIIO and the grantee receives a written response can the grantee alter the award.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q23:** May a State change the principal investigator on the grant?	**A23:** A change of principal investigator is a substantive change; a State will have to seek prior approval from CCIIO before instituting any such change.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q24:** After the States have been awarded funding and conduct their Exchange activities, does CCIIO have plans to share best practices?	**A24:** States are expected to carry out due diligence in seeking opportunities for reuse, sharing, and collaboration in Exchange Activities. States are to evaluate opportunities for reuse of materials and knowledge from within their own State, as well as other States, and the Federal Exchange(s). States are encouraged also to identify opportunities for collaboration with other States that might help reduce both development and long-term operating costs of their Exchange. HHS will work closely with States during the project period to help them identify	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

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		opportunities for both reuse and collaboration.			
Exchange Establishment Cooperative Agreement Funding	**Q25:** Some States already operate an Exchange. Do these States qualify for Exchange Establishment grants?	**A25:** Yes. States that already have an Exchange may use Exchange grants to fund activities related to implementing changes necessary to bring their existing Exchange into compliance with the Exchange requirements set forth in the Affordable Care Act.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q26:** How can individuals and the general public be involved in the establishment process for the Exchanges?	**A26:** States may continue the stakeholder consultation initiatives begun during the planning phase throughout the establishment process. Stakeholder consultation was required as part of activities in connection with Exchange Planning grants. Stakeholders include, but are not limited to, consumer organizations, small business organizations, health plans, safety net associations, and faith based organizations. All States were required to seek stakeholder input and involvement in planning for Exchanges. Additionally, all States have to meet a standard of transparency and accountability if they elect to establish a State-based Exchange. CCIIO will monitor this aspect of the Establishment grants and provide technical assistance to share best practices in this area.	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Exchange Establishment Cooperative Agreement Funding	**Q27:** Are there parameters defining what constitutes excessive executive	**A27:** Only allowable costs may be paid using grant funds. Executive compensation must be an allowable cost and should reflect the market rate for a	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html

Category	Question	Answer	FAQ Title	Agency	Site
	compensation?	similar position in your area. For more information relating to allowable costs, see the OMB Circular A-110, item #27, at http://www.whitehouse.gov/omb/circulars_a110#27. New grantees awarded under this Funding Opportunity Announcement should be aware they are subject to the reporting requirements of the Federal Funding Accountability and Transparency Act of 2006 (Pub. L. 109-282), as amended by section 6202 of P.L. 110-252, and implemented by 2 CFR 170. Grant and cooperative agreement recipients must report information for each first-tier subaward of $25,000 or more in Federal funds and executive total compensation for the recipient's and subrecipient's five most highly compensated executives.			
Exchange Establishment Cooperative Agreement Funding	**Q28:** What type of technical assistance will be available to States?	**A28:** The program offers many types of technical assistance to States, including: ■Webinars ■Conference calls ■"Office hours" with program staff at industry conferences and meetings ■Grantee conferences/meetings	FAQ November 9, 2012	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Exchange-establishment-faq.html
Using Section 1311(a) Funding for Marketing	**Q1:** May states in a Plan Management	**A1:** Yes. FFM States or PM SPMs may conduct statewide marketing activities	FAQ April 23, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketplace-

Category	Question	Answer	FAQ Title	Agency	Site
Activities in a Plan Management State Partnership Marketplace or Federally-facilitated Marketplace	(PM) State Partnership Marketplace (SPM) or states in which the federal government will operate a Federally-facilitated Marketplace (FFM States) apply for and use Section 1311(a) funding to engage in marketing activities (including but not limited to production and distribution of brochures, direct mail, print ads, social media and digital/online ads, and TV and radio buys) related to the PM SPM or FFM, even though they are not participating in a State-based Marketplace or a Consumer State Partnership Marketplace?	to promote the PM SPM or FFM using Section 1311(a) grant funds provided they meet the following criteria: •Materials must use federal messages and language, which can be found on the CMS Marketplace website: http://marketplace.cms.gov/index.html - Opens in a new window under the " Explore Research - Opens in a new window " tab. •All marketing activities carried out in FFM States or PM SPMs must be performed in coordination with the U.S. Department of Health and Human Services (HHS). For example, materials produced by the state must be shared with HHS in advance of printing and distribution. Ample time must be allowed for HHS to review and provide any necessary feedback (usually within 30 days). •Materials must be 508 compliant and accessible to persons with disabilities and persons with limited English proficiency.			funding-marketing-faq.html
Using Section 1311(a) Funding for Marketing Activities in a Plan Management State Partnership Marketplace or Federally-facilitated	**Q2:** May PM SPMs or FFM States that choose to produce their own marketing materials include a state logo on them or	**A2:** States participating in PM SPMs or FFM States that choose to produce their own marketing materials are permitted to place a single state emblem (such as the state flag or seal) on the materials in place of the HHS seal. However, the	FAQ April 23, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/marketplace-funding-marketing-faq.html

Category	Question	Answer	FAQ Title	Agency	Site
Marketplace	otherwise brand the materials?	Federal Health Insurance Marketplace logo must appear on the materials. PM SPMs and FFM States may not otherwise brand their materials. As stipulated in the January 3, 2013 Guidance on the State Partnership Exchange, only states in a Consumer State Partnership Marketplace may brand their consumer assistance programs, including Navigators and In-person counselors, by using a separate logo or brand, such as a distinct name and tagline, developed to unify all consumer assistance components.			
Allowable Uses of Section 1311 Funding for States in a State Consumer Partnership Marketplace	**Q1:** If a state is in a State Consumer Partnership Marketplace, what types of activities are allowable uses of 1311 funds?	**A1:** For states that are in a State Consumer Partnership Marketplace, the list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential eligible activities. States are encouraged to consult with HHS regarding the use of 1311 funds for these and other activities before submitting grant applications or expending funds. As CMS recently advised, Affordable Care Act section 1311(i)(6) prohibits Marketplaces from using section 1311(a) grant funds to fund Navigator grants. See 78 Fed. Reg. 20581, 20583-84: http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf. In State Consumer Partnership	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ca-spm-funding.html

Category	Question	Answer	FAQ Title	Agency	Site
		Marketplaces, Navigators are a federal responsibility funded by a separate federal grant program. Section 1311(a) grant funds are available for non-Navigator assistance programs (also known as "in-person assistance programs") in Consumer Partnership Marketplaces because the state has elected to establish and operate outreach, educational, and assistance activities as a condition of its participation in the Consumer Partnership Marketplace and to assist in its possible transition to a State-based Marketplace. See the 1/3/2013 Guidance on the State Partnership Marketplace. In State Partnership Marketplaces, the non-Navigator Assistance Program will supplement – not supplant – the Navigator Program, which is administered by HHS. Additionally, while section 1311(i)(1) directs that the federal Navigator program be a grant program, state partners in a Consumer Partnership Marketplace have the flexibility to build a non-Navigator assistance program through contracts, direct hiring, or grants, subject to state law. **State Activities (Consumer and Stakeholder Engagement and Support)**			

Category	Question	Answer	FAQ Title	Agency	Site
		•Build and fund first year operations of an in-person assistance personnel (IPAs) program (also known as "non-Navigator assistance personnel") •Help HHS ensure that Navigators and IPAs have completed required federal training and passed required federal exam •If the state so chooses, create supplemental training materials for Navigators and IPAs that include state-specific component •Help HHS ensure that Navigators and IPAs are educated about and know how to refer consumers to Consumer Assistance Programs (CAPs) throughout the state as appropriate •Assist HHS in monitoring the conduct and performance of Navigators and report any noncompliance •Establish mobile units throughout the state to help individuals complete Marketplace eligibility applications and choose a Qualified Health Plan (QHP) •Provide consumers/stakeholders with information about how the Pre-existing Insurance Plan (PCIP) program transition will occur and assist PCIP enrollees transitioning to the Marketplace •Develop and execute, with HHS approval, activities to publicize Marketplace activities in the state •Engage local stakeholders in the role of disseminating Marketplace information			

Category	Question	Answer	FAQ Title	Agency	Site
		to eligible populations •Coordinate with other health and human services organizations in the state to broaden outreach (such as Marketplace information on applications for other programs, websites, emails or through IPA call centers) •Develop state-specific materials – or use those developed by the FFM – to educate consumers about eligibility and enrollment options as well as benefits and services available through the Marketplace •Produce and disseminate marketing/campaign materials, including but not limited to: brochures, direct mail, print ads, social media and digital/online ads, and TV and radio buys. Materials must use federal messages and language and conform to other requirements detailed in the Marketing FAQ •Ensure that public education and outreach materials are culturally and linguistically appropriate, and accessible for persons with limited English proficiency and disabilities •Brand the State's consumer assistance program (Navigators, IPAs) with a single identity such as a distinct name and tagline to use on a consumer website, earned and paid media, and outreach and education activities •Provide tailored search capabilities on any branded in-person assistance			

Category	Question	Answer	FAQ Title	Agency	Site
		website •Ensure that the IPA program is consistent with all applicable federal regulations and guidance •Manage State IPA program so that it coordinates with the Federal Navigator program in order to avoid duplication of efforts •Identify and recruit in-person assistance personnel •Help ensure that all Navigators and IPAs adhere to federal conflict-of-interest standards; all materials comply with Culturally and Linguistically Appropriate Services (CLAS) standards; and all categories of in-person assisters have received training on privacy and security standards concerning the handling of Personally Identifiable Information (PII) •With HHS, resolve any problems or complaints about IPAs reported directly to the State Marketplace or referred from the federal complaint tracking system **State Activities (SHOP)** •Help HHS monitor Navigators to ensure that Navigators are reaching out to and trained to assist small businesses with enrollment in SHOP plans. •Operate an IPA program that will assist small businesses with enrollment in SHOP plans			

Category	Question	Answer	FAQ Title	Agency	Site
		State Activities (Contracting, Outsourcing, and Agreements) •Inform HHS about contracting and outsourcing agreements			
Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace	**Q1:** In a state in which the federal government will operate an FFM, including an SPM, what types of activities are allowable uses of 1311 funding?	**A1:** The list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential activities. States are encouraged to consult with HHS regarding the use of 1311 funds for these and other activities associated with enabling a successful FFM. **State Activities (Consumer and Stakeholder Engagement and Support)** •Develop a Marketplace stakeholder list and participate in stakeholder consultations, including tribal consultations, with HHS. •Compile and share with HHS information on any state licensure requirements impacting Navigators •Perform analysis necessary to develop policy options and decisions on the role of agents, brokers, and web brokers •Gather and share with HHS state contact and certification/ licensure information on agents/brokers •Share with HHS relevant state consumer assistance resources information •Under defined limits, perform consumer outreach and education	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html

Category	Question	Answer	FAQ Title	Agency	Site
		•Gather and share state-specific content for FFM web portal with HHS **State Activities (Plan Management)** •Perform analysis necessary to develop policy options and decisions about health insurance market regulation •Compile and share with HHS and the Office of Personnel Management information on state efforts related to plan quality, issuer monitoring and oversight, and performance data •Support process to review Consumer-Operated and Oriented Plans (CO-OPs) for state licensing •Perform analysis necessary to support policy options and decisions regarding state-based standard population for actuarial value calculations •Engage with HHS regarding formal information collection process around complaints and fraud referrals **State Activities (Risk Adjustment and Reinsurance)** •Analysis and decision-making for reinsurance program policies •For states with Department of Health and Human Services (HHS) administered reinsurance and risk adjustment programs: ◦Engage with HHS around reinsurance and risk adjustment planning and operation •For states that operate reinsurance:			

Category	Question	Answer	FAQ Title	Agency	Site
		◦Assess and confirm appropriate legal authority to operate reinsurance ◦Issue payment notice ◦Support reporting for oversight and monitoring of reinsurance •For states that opt to collect additional reinsurance or administrative contributions, and/or use more than one reinsurance entity: ◦Publish the modifications in the state notice of benefit and payment parameters **State Activities (Small Business Health Options Program (SHOP))** •Gather and share with HHS information related to the state's small group market, and a state's preferences for collaboration with the Federally-facilitated SHOP (e.g. state definition of small employer) **State Activities (Oversight, Monitoring & Reporting)** •Provide information on types and format of states' issuer compliance data, issuer performance data, and other performance data necessary for oversight and monitoring •Preview, test, and participate in training on complaint tracking **State Activities (Market Issues)** •Gather and share with HHS information related to collaborative			

Category	Question	Answer	FAQ Title	Agency	Site
		enforcement, market environment, and other model-specific implementation issues			
Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace	**Q2:** If a state has acknowledged interest in performing plan management activities, what types of activities are allowable uses of 1311 funds?	**A2:** For states that have acknowledged interest in performing plan management activities, the list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential activities. States must consult with HHS regarding the use of 1311 funds for these and other activities. **State Activities (Legal Authority and Governance)** •Assess and confirm appropriate legal authority to operate a Plan Management Partnership or perform plan management activities **State Activities (Eligibility & Enrollment)** •Develop Pre-existing Condition Insurance Program (PCIP) transition plan **State Activities (Plan Management)** •Coordinate the development of an agreement to support State-operated plan management functions with other	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html

Category	Question	Answer	FAQ Title	Agency	Site
		state agencies as applicable •Determine and share with HHS information regarding the entity performing PM Partnership functions and governance structure •Develop and publish Qualified Health Plan (QHP) application, develop and implement a QHP certification process consistent with Federal requirements (including for stand-alone dental plans and CO-OPs), and collaborate with HHS throughout certification process •Develop an approach to ensure QHP issuers meet accreditation requirements •Collect and transmit issuer and plan data to HHS to support QHP certification and Marketplace operations •Collaborate with HHS during the plan preview period for issuers and develop a process for making necessary corrections to plan data •Develop day-to-day issuer account management activities, including serving as point of contact for issuer questions and issues related to QHP certification and responsibilities; managing communications with QHP issuers and the FFM related to Marketplace issues and monitoring; developing processes to resolve consumer complaints; and track and coordinate as necessary with FFM •Develop general approach to ensuring QHP compliance and monitoring QHP performance			

Category	Question	Answer	FAQ Title	Agency	Site
		•Coordinate with the FFM on Marketplace operational oversight (i.e. compliance with Marketplace standards) and develop a process for taking compliance actions against QHP issuers when necessary •Develop notice of deficiency for QHP certification, and appeal notice for QHP recertification and decertification •Conduct other quality or performance monitoring at the discretion of the State. •Participate in consultations and other checkpoints with HHS •Develop a work plan for supporting issuers and providing TA •Create necessary plan management information technology (IT) systems and ensure connections are tested and operational **State Activities (Oversight, Monitoring & Reporting)** •Conduct routine oversight and monitoring of the state's PM activities •Track/report performance and outcomes metrics related to the state's PM activities			
Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace	**Q3:** Does 1311 funding cover Marketplace costs for preparing to transition from a FFM model to an SPM or SBM?	**A3:** Yes, the November 30, 2012 FOA clarifies that §1311(a) grant funds allow states the flexibility to transition between Marketplace models over time. Per the FOA and the Blueprint for Approval of State-Based and State Partnership Insurance Exchanges2 (http://cms.gov/cciio/resources/factsheet	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html

Category	Question	Answer	FAQ Title	Agency	Site
		s/hie-blueprint-states.html), published November 9, 2012, the state must develop a transition plan with HHS, comply with Marketplace Blueprint requirements, submit a Model Declaration Letter and Marketplace Blueprint Application on applicable timelines, and obtain approval or conditional approval from CCIIO 12 months before the start of the plan year.			
Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace	**Q4:** Can Section 1311 funding be used to support activities related to Medicaid/CHIP administrative, policy or systems activities involved in interfacing with an FFM?	**A4:** Per guidance released October 5, 2012 ("Supplemental Guidance on Cost Allocation for Exchange and Medicaid IT Systems4" http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/Key-Cost-Allocation-QAs-10-05-12.pdf), in a FFM or SPM state that has not declared its intent to transition to a SBM in 2015, SBM, Marketplace funds may not be used to improve systems or processes related to Medicaid/CHIP interfaces with the Federally-Facilitated Marketplace. This includes building systems designed to coordinate with the FFM, to manage applicant account, such as connecting with the hub and augmenting the federal call center.	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html
Allowable Uses of Section 1311 Funding for States in a State Partnership Marketplace or in States with a Federally-Facilitated Marketplace	**Q5:** What if a state, through modernizing their Medicaid/CHIP eligibility and enrollment system, is not ready to affirm	**A5:** Yes, if a State opts to establish a State-based Marketplace later, Marketplace establishment funding would be available prospectively to transform systems, subject to approval from CMS, and assuming it is properly	FAQ May 13, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/spm-ffm-funding.html

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	its intent to build a State-Based Marketplace? If the State later opts to establish a State-based Marketplace and therefore request grant funds to make the transformation, does it allocate costs to the Marketplace grant in order to make that transformation?	represented and characterized in the application for grant funding. However, please note that the availability of Marketplace establishment funding (and therefore ability to readjust cost allocation on a prospective basis taking that funding into account) is subject to certain timelines, and States will need to make decisions about their intention to establish a State Marketplace along that timing in order to receive such funding.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q1:** What are Territory Cooperative Agreements for the Affordable Care Act's Exchanges?	**A1:** The Affordable Care Act authorizes Planning and Establishment Cooperative agreements to help States and Territories establish health insurance Exchanges. On January 20, 2011, HHS issued a cooperative agreement solicitation (also referred to as a Funding Opportunity Announcement, or FOA) publicizing the availability of the first round of funding for these cooperative agreements - up to $1 million for each Territory. Although Exchanges are not required to be operational until 2014, work is already underway to conduct implementation activities. These cooperative agreements will give Territories the resources to begin the early implementation activities needed to build a better health insurance marketplace and lay the groundwork for an operational	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		Exchange. Territories can use these funds for a variety of Exchange implementation activities including, but not limited to: • Assessing current information technology (IT) systems and determining any Exchange IT needs; • Implementing consumer call centers to answer Exchange questions from their residents; • Developing partnerships with community organizations to gain public input into the Exchange process. For more information, including a link to the FOA, go to http://www.grants.gov - Opens in a new window and search for CFDA 93.525.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q2:** When are Territory Cooperative Agreement applications due?	**A2:** Applications must be filed by February 22, 2011.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q3:** How will we know if our application has been received by the Center for Consumer Information and Insurance Oversight (CCIIO)?	**A3:** After submitting their application materials online through Grants.gov, applicants will receive two emails: 1) confirming receipt of the application by Grants.gov, and 2) confirming that the application has been validated. Applicants can also check the status of their application on Grants.gov.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's	**Q4:** How do I download the application? What do	**A4:** You can access the electronic application for this project on http://www.grants.gov - Opens in a new	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15

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Exchanges	I do if I encounter problems with this process?	window. You must search the downloadable application page by the CFDA number 93.525. On the Grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. CCIIO strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov - Opens in a new window. Please see page 10 of the FOA for additional information.			_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q5:** What if a Territory has an ongoing issue with obtaining the Central Contractor Registry (CCR) number or the correct Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number?	**A5:** If a Territory has ongoing issues with obtaining a CCR or DUNS number, it must receive a case number from the respective system. The Territory should then inform CCIIO of the delay and provide the case number.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q6:** How do we fill out the mandatory document "Disclosure of Lobbying Activities" if we do not have any	**A6:** The Lobbying Form has yellow fields that applicants must complete. If the applicant does not engage in Lobbying activities it can respond to the Section Fields #4, #6, and #11 and respond with an N/A for Section Fields	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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	lobbying activities to disclose?	10a & 10b.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q7:** Should the documents that are submitted as attachments to the cooperative agreement application be in PDF or Word format?	**A7:** http://www.grants.gov - Opens in a new window and CCIIO will accept Word or PDF attachments. However, if an applicant submits an attachment in Word and receive an error message regarding the attachment, the applicant should convert the Word attachment into a PDF attachment and then resubmit the application. Note: http://www.grants.gov - Opens in a new window requires each attached file to have a unique file name.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q8:** Can you describe the method by which funds will be disbursed to the Territories if a cooperative agreement application is approved?	**A8:** Cooperative agreement funds are disbursed on an ongoing basis to the Territory upon receipt and approval of a payment request. More detailed instructions for submitting payment requests and the process of approval will be provided in the award letter and the cooperative agreement terms and conditions.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q9:** Who is the point of contact for questions related to these cooperative agreements?	**A9:** For cooperative agreement-related (i.e., business issues, how to submit the cooperative agreement, budget questions) questions about the cooperative agreement announcement, please contact: Michelle Feagins Office of Consumer Information and Insurance Oversight Department of Health and Human	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		Services (301) 492-4312 Michelle.Feagins@hhs.gov For Program Requirement questions, please contact: Katherine Harkins Office of Consumer Information and Insurance Oversight Department of Health and Human Services (301) 492-4445 Katherine.Harkins@hhs.gov			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q10:** Is US Mail the only the only way the awardees will be notified of their cooperative agreement awards?	**A10:** At this time, we also plan to email the notice of cooperative agreement award to successful applicants.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q11:** Will HHS provide any guidance or assistance on completing the application process?	**A11:** CCIIO held a pre-application conference call for potential applicants on Wednesday, January 26, 2011 at 4:30 PM EST. The conference provided an overview of this project guidance and include an opportunity for Territories to ask questions. The toll-free number is 800-779-5194. Callers from American Samoa and the Northern Mariana Islands should use 1-630-395-0068. The participant passcode is 2909328. A recording and transcript of the call are	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		available on HHS's website. The pre-application call information is available in the FOA.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q12:** Page 7 of the FOA indicates that the governor must designate a Territorial entity as the cooperative agreement applicant. What is a "Territorial entity"?	**A12:** Territories are the only eligible applicants for this cooperative agreement solicitation. A Territorial entity is either a Territorial agency, such as the Territorial Medicaid agency or Department of Insurance, or an independent Territorial agency. Non-profits and other nongovernmental corporate entities are not eligible to apply for these cooperative agreements. Territories may choose to subcontract the cooperative agreement's implementation activities to a non-profit entity, but the Territory is the party ultimately responsible for compliance with the terms and conditions of the cooperative agreement. If a Territory engages one or more subcontractors, it must provide CCIIO with the letter or letters of agreement describing these relationships and each contractor's scope of work. Please see page 19 of the FOA for information on this requirement.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q13:** Page 13 of the FOA list a variety of topics that must be addressed in the project narrative section of the	**A13:** CCIIO is not requiring subheadings or separate sections for each of the topics listed in the project narratives. The items included in the project narrative topic descriptions are merely examples designed to illustrate	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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	cooperative agreement application. Each topic description contains a list of items that may be addressed by the applicant. Does CCIIO want subheadings for each of the project narrative items, or does each item need to be in a separate section?	what we are looking for in this section of the application; not every item listed in the topic description must be addressed in the application. Sections and subheadings should be used in a manner that would aid the reader. Page 20 of the FOA provides information on review criteria for this award, including how much each section will be weighted during the review process.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q14:** Page 23 of the FOA indicates that consumers and other stakeholders must have meaningful involvement in the implementation, and evaluation of the project. The timeline for this cooperative agreement may make it difficult to engage stakeholders. How does a Territory address that in its cooperative agreement application?	**A14:** You must describe how you will engage stakeholders in your application. We believe the activities funded by these cooperative agreements will occur over a significant period of time that is sufficient to ensure an opportunity for stakeholders to have meaningful input.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative	**Q15:** Page 23 of the	**A15:** This section, Administrative and	FAQ February	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Agreements for the Affordable Care Act's Exchanges	FOA indicates that all cooperative agreement budgets must include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families. What should costs associated with these accommodations be treated?	National Policy Requirements, notes that if under this cooperative agreement a Territory conducts any consultations with stakeholders, it must ensure that it facilitates the participation of individuals with disabilities. You do not need to itemize these costs specifically, but Territories should ensure that they budget for costs of that type.	15, 2011		orms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q16:** As part of the application, the Territory is required to submit a Project Site Location Form (OMB No. 4040-0010). Is this form only for Territories that use a subcontractor for the cooperative agreement activities?	**A16:** This is a required form from the Office of Management and Budget. The Territory must designate the location of the applicant Territorial entity. If a Territory is contracting any cooperative agreement activities out to another entity, the Project Site Location Form should nevertheless specify the Territorial applicant's address.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q17:** Can you provide additional information about the Federal requirements outlined in the finance section of the Project Narrative requirements?	**A17:** The Project Narrative should address how the Territory will ensure the financial integrity of the Exchange that it is implementing. With respect to the financial integrity of the Exchange, Territories should plan for how their Exchanges will meet the requirements set forth in Section 1313 of the	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		Affordable Care Act. Territories should plan for how they will use funds and track expenditures. We refer you to requirements in Section 1313 of the Affordable Care Act including annual audits of Exchanges and requirements on preventing fraud and abuse. We want your proposal to include your progress on how you plan to meet these requirements.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q18:** If some Territories do not submit proposals for Territory Cooperative Agreements, could Territories that need more funding for Exchange implementation activities submit a larger budget?	**A18:** No. Each Territory may receive up to $1 million as a result of this cooperative agreement solicitation. We will work with the Territories so they can apply for future opportunities for additional funding.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q19:** If a Territory does not have an approved agreement for indirect costs, may it use an estimated rate and then submit a Change in Scope later on?	**A19:** No. A Territory must establish an indirect cost rate within the appropriate office or agency before it includes an indirect cost rate in the proposal. If a Territory does not have a rate by the time it needs to submit its proposal, the Territory may request to change its proposal to include the indirect rate that is subsequently established.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the	**Q20:** Item 2 of the Attestation discusses	**A20:** Item 2 of the Attestation refers to the grant funds to plan for and establish	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-

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Affordable Care Act's Exchanges	eligibility for Federal funding under Section 1311(a). Does this refer to State planning and establishment grant funds, or the funds dedicated for the Territories in Section 1323?	an Exchange as announced in this FOA No. IE-HBE-11-003, Territory Cooperative Agreements for the Affordable Care Act's Exchanges.			Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q21:** Can you clarify Item 4 on the Health Insurance Exchange Territory Attestation Election to Establish an Exchange Consistent with Federal Requirements?	**A21:** Item 4 of the Attestation should read: The Territory acknowledges that if an election is received by the Secretary of the Department of Health and Human Services on or before October 1, 2013, pursuant to Section 1323(b), the Territory shall not be entitled to apply funds provided for premium and cost sharing assistance in its Exchanges to the Territory's Medicaid program. Successful applicants will be required to sign this updated version of the attestation as part of the Terms and Conditions of their Notice of Grant Award.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q22:** Is it permissible to use the cooperative agreement funds for Territorial travel costs to Federally-	**A22:** Yes, the cooperative agreement funds can be used for Territorial travel costs to Federally-sponsored meetings related to the cooperative agreements. To the extent possible, these costs are to be outlined in the budget narrative.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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	sponsored meetings related to the cooperative agreements?	Applicable OMB cost principles will be followed in determining the reasonableness, allowability and allocabilty of costs			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q23:** If a Territory is using existing staff to work in new positions on Exchange activities, can it use cooperative agreement funds to pay for the existing staff?	**A23:** Yes. Cooperative agreement funds may be used to pay compensation to existing staff for that portion of their time spend working on activities related to the establishment of an Exchange, regardless of whether the staff was previously assigned to other duties or another position. It is acceptable that the staff for the Exchange activities is obtained through other offices. Cooperative agreement funds may not be used to fund positions for personnel who will not be working on activities related to the establishment of an Exchange.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q24:** May these cooperative agreement funds be used primarily to hire personnel?	**A24:** These cooperative agreement funds must be used for activities related to implementation of Exchanges. The proportion of cooperative agreement funds used to hire or contract with personnel for these activities will depend on the needs of the cooperative agreement applicant.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q25:** Where will funding come from for Exchange IT functions?	**A25:** We anticipate future funding opportunities to be made available to the successful awardees under this FOA; funding from such future awards might be used to fund IT system changes for the Exchange side of eligibility and enrollment operations. Only Medicaid	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		funds should be used to fund Medicaid-specific systems changes.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q26:** When can Territories draw down the Exchange cooperative agreement funds?	**A26:** The cooperative agreement cycle starts on March 22, 2011 and ends after one year. Territories have up to 12 months to draw down funding from this cooperative agreement cycle.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q27:** May a Territory spend cooperative agreement funds from this cooperative agreement cycle after March 22, 2012?	**A27:** If a Territory wants a no-cost extension, it can seek prior approval from CCIIO for the extension.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q28:** The FOA requires applicants to provide documents confirming actual or pending agreements with subcontractors. How does a Territory identify subcontractors in its proposal if it doesn't know who it will be subcontracting with due to Territorial procurement requirements?	**A28:** If a Territory cannot name specific subcontractors, it should indicate this in the proposal and identify the tasks a subcontractor may perform.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q29:** Can a Territory contract out a majority of the work associated with the cooperative	**A29:** Yes. The Territory remains responsible for ensuring that all subcontractors are selected in accordance with 42. C.F.R. § 92.36 and that entities awarded such contracts	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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	agreement?	comply with the terms and conditions of the cooperative agreement. Recipients of Cooperative Agreement must submit to HHS the required information establishing a third-party contract to perform program activities (see Required Information for Contract Approval in Attachments E, F and G in the FOA). 1. Name of Contractor; 2. Method of Selection 3. Period of Performance; 4. Scope of Work; 5. Method of Accountability; and 6. Itemized Budget and Justification. If the above information is unknown for any contractor at the time the application is submitted, the information may be submitted at a later date as a revision to the budget.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q30:** May a Territory change the principal investigator on the cooperative agreement?	**A30:** A cooperative agreement awardee may request changes to its proposal to a cooperative agreement award. If an awardee would like to make a substantive amendment to its cooperative agreement award after the	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		project year has begun, that change will be considered a Change in Scope and must be approved by CCIIO. A request for approval of the Change of Scope must be submitted to the Program Official. Only after the Change of Scope is approved by CCIIO and the cooperative agreement awardee receives a written response, can the awardee alter the award. A change of principal investigator is a substantive change; a Territory will have to seek prior approval from CCIIO before instituting any such change.			
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q31:** After the Territories have been awarded funding and conduct their Exchange implementation activities, does CCIIO have plans to share best practices?	**A31:** We anticipate convening Territories for this purpose, and will announce such plans when they are finalized.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html
Territory Cooperative Agreements for the Affordable Care Act's Exchanges	**Q32:** If a Territory applies for funding under this solicitation and does not establish an Exchange, is the Territory required to repay any grant funds?	**A32:** Yes. In order for a Territory to be eligible for Exchange establishment funding under Section 1311 of the Affordable Care Act, the Territory must submit a signed attestation along with its application for this funding opportunity, stating its intention to establish an Exchange.	FAQ February 15, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/territories_external_faq_2_15_2011.html

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		If, after that attestation, the Territory ultimately does not establish an Exchange, it voids its previous eligibility for Section 1311 funds. The Territory is then responsible for repaying any money it had drawn down under this cooperative agreement.			
Risk Adjustment Implementation Issues	**Q1:** Why is this paper being announced now?	**A1:** This paper is being released to coincide with the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment NPRM comment window, which closes on September 28, 2011, because it provides context for individuals wishing to submit comments in response to the NPRM. Importantly, this white paper provides a more detailed technical discussion of several elements of the NPRM. In addition, HHS is beginning the development of a Federal risk adjustment methodology, and comments received in response to this white paper will assist HHS in this effort.	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html
Risk Adjustment Implementation Issues	**Q2:** How does this paper relate to the recently released Standards Related to Reinsurance, Risk Corridors and Risk Adjustment NPRM?	**A2:** This white paper provides a more technical description and analysis of issues related to the development of a federally-certified risk adjustment methodology than was contemplated in the NPRM. This paper is a draft meant for discussion purposes only and does not represent final policy.	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html
Risk Adjustment Implementation Issues	**Q3:** What is included in this white paper?	**A3:** This white paper provides a more detailed technical discussion of several elements of the NPRM. In particular,	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementati

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		this paper discusses methodological choices in developing a Federal risk adjustment model, describes potential approaches to calculate payments and charges, and addresses permissible rating variation. The paper places emphasis on payments and charges and permissible rating variation because these topics are particular to the Affordable Care Act and provides further detail on preliminary approaches to examine the implications for premiums of various payment and charges alternatives.			on_issues.html
Risk Adjustment Implementation Issues	**Q4:** Is there opportunity for comment or feedback on this paper, and if so, how?	**A4:** Yes. Comments in response to this white paper may be submitted to the email address RiskAdjustmentIssues-2011@cms.hhs.gov. There is no deadline to submit comments to this white paper; we see this as a part of an ongoing consultation process. However, these comments will not become part of the administrative record that will be the basis of the final risk adjustment proposed rule. Comments in response to the white paper will be used by HHS in developing the first annual Federal payment notice that will appear in the Federal Register and will include a draft notice and a comment period before the notice (and methodology) is finalized. While this white paper should serve to inform comments to the NPRM, comments in response to questions	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html

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		raised in the NPRM should be submitted at the regulations.gov website, where they will become part of the administrative record for the NPRM.			
Risk Adjustment Implementation Issues	**Q5:** Did any public input go into the drafting?	**A5:** This paper was drafted as part of an ongoing consultation process with States, issuers, risk adjustment experts and other stakeholders. In keeping with the commitment to transparency, this white paper is intended as the first in a series of consultations that will include meetings and other opportunities for feedback. HHS is seeking comments on this white paper to inform the development of a federally-certified risk adjustment methodology. The methodology will be released as part of a Federal Payment Notice that will appear in the Federal Register. Before finalizing the Payment Notice and the federally-certified methodology, HHS will issue a draft notice and take public comment.	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html
Risk Adjustment Implementation Issues	**Q6:** What are the next steps?	**A6:** Comments in response to this white paper will be considered as HHS begins the process of developing a federally-certified risk adjustment model. Comments will inform the HHS-developed federally-certified risk adjustment methodology, which will be released as part of a Federal Payment Notice that will appear in the Federal Register and will include a draft notice and a comment period before the notice	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html

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		(and methodology) is finalized. Comments in response to the NPRM will be addressed in the rule making process.			
Risk Adjustment Implementation Issues	**Q7:** What is risk adjustment? To whom does it apply?	**A7:** To minimize the negative effects of adverse selection and foster a stable marketplace from year one, the Affordable Care Act establishes transitional reinsurance and temporary risk corridor programs, and a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The risk adjustment program is designed to protect issuers that attract a high risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower risk enrollees to issuers with higher risk enrollees. This is a State-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of Exchanges. The risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection, or choices by higher risk enrollees in the individual and small group markets. The risk	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html

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		adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability in markets inside or outside of the Exchange.			
Risk Adjustment Implementation Issues	**Q8:** What is included in the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment NPRM?	**A8:** The NPRM proposes standards related to the risk adjustment program. The NPRM proposes that a uniform set of data for risk adjustment be considered. This reduces burden on health insurers that offer qualified health plans in different States by creating uniform reporting standards. It proposes that risk adjustment calculations occur at the State, rather than plan or Federal level, given States' role in the system. And while a Federal risk adjustment methodology would be developed, States electing to run their own risk adjustment program could use an approved alternative methodology. This white paper is intended to provide context for comments in response to the NPRM.	FAQ September 12, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/risk_adjustment_implementation_issues.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q1:** Can the Centers for Medicare & Medicaid Services (CMS) provide additional guidance on the establishment of the Private Purchasing Council, such as:	**A1:** The statute provides wide latitude in the operation of purchasing councils to buy services such as third-party administrative services, reinsurance or IT functions for CO-OPs that would result in lower administrative costs. The statute envisions that purchasing councils are formed by the CO-OPs as separate organizations. In addition, there	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	a. Are there any limitations on functions performed beyond those mentioned in the statute? b. Does a separate entity need to be established? If so, are there limitations on form, such as LLC, Partnership, Schedule C, or Non-Profit? c. Could the council act as a management organization for multiple CO-OPs to achieve development or administrative efficiencies? d. If a separate entity needs to be established, could external organizations own all or part of the council, if not otherwise subject to any of the predecessor or related entity regulations?	is no barrier to a purchasing council providing management functions for a CO-OP or group of CO-OPs, but a CO-OP in its application would need to clearly describe the management functions performed directly by the CO-OP, what functions it anticipates delegating to a purchasing council or other third party, and what the effects would be on the overall management and governance of the CO-OP.			
Consumer Operated and Oriented Plan (CO-OP)	**Q2:** Please provide additional guidance	**A2:** a. Under the Funding Opportunity Announcement of December 9, 2011,	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Program	on what is included in the 75 page limit. a. Are the Excel spreadsheets for the pro-forma financial statements and other supporting models (i.e. bylaws) considered part of the 75-page limit, or can they be considered as attachments? b. If an applicant intends to set up a multi-state CO-OP, are they limited to this 75 page limit?	the application narrative may not exceed 75 pages. This includes: the application cover letter, the application abstract, the project narrative, and the business plan (not including pro forma financials, resumes, and any other supporting Excel documents). This 75 page limit does not include: Standard Forms (i.e. SF 424), the feasibility study certification and analysis, organizational charts, position descriptions, resumes, pro forma financials and other business plan attachments, supporting excel documents, governance and licensure requirements, evidence of nonprofit status, relevant statutory and regulatory citations regarding state licensure, eligibility affidavit and application certification, affidavit(s) of criminal and/or civil proceedings, affidavit of eligibility to participate in federal programs, and evidence of private support. Applicants may upload these additional appendices as separate attachments. b. If an applicant intends to set up a multi-state CO-OP, they are expected to discuss their overall feasibility study and business plan within the 75-page limit. However, applicants may use appendices to further describe their State specific feasibility studies and			

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		business plans. Such appendices would not be included in the 75-page limit.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q3:** Is it acceptable to incorporate generic nonprofits that have the mission to develop a CO-OP plan but that do not have a stated explicit insurance purpose and are not incorporated as an insurance entity so as to meet timeline?	**A3:** As finalized at 45 CFR 156.515, applicants must be incorporated as a non-profit member organization. However, applicants need not be incorporated or licensed as an insurance entity provided that the applicant entity is able to become a licensed issuer within the prescribed time period. The applicant must be the entity that ultimately becomes a CO-OP. Under the Final Rule, applicants should have a plan for achieving licensure and offering a qualified health plan in the Affordable Insurance Exchanges within three years of receiving Start-up Loan funds or within one year of receiving Solvency Loan funds.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q4:** Must an eligible applicant be incorporated as a non-profit member organization specifically within the State it intends to organize a future CO-OP in order to be awarded a CO-OP loan?	**A4:** Under the Final Rule, an applicant is not required to be incorporated as a non-profit member organization in each State in which it intends to organize a CO-OP. It must, however, be authorized to do business in any State where it intends to offer coverage. A successful applicant must eventually be licensed by the State insurance agency, either as a domicile issuer or a foreign issuer operating with an expansion license in every State in which it intends to provide health insurance coverage.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP)	**Q5:** Is it permissible to set up a	**A5:** No, under the Final Rule, the nonprofit entity that will become the	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Program	relationship between the sponsoring organization and the CO-OP entity whereby the sponsoring organization applies for the loan on behalf of the future CO-OP, with a plan for transitioning the loan to the CO-OP entity once created?	CO-OP after receiving funds will need to submit the application. As stated in response to Question #4, applicants need not be incorporated as an insurance entity provided that the applicant entity is able to become a licensed issuer within the prescribed time period.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q6:** What does CMS expect applicants to have in place with vendor partners at the time of the application (i.e. Letters of Intent with networks, reinsurers, etc.)?	**A6:** Consistent with the Funding Opportunity Announcement, we expect that applicants will either have identified strategic operational partners or be able to describe a plan for developing specific partnerships with provider networks, reinsurers, etc., and provide documentation of existing relationships with vendor partners. This could be demonstrated with a Letters of Intent or Support. It is not expected that formal obligations will be in place at the time of application or that negotiations will be completed.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q7:** What happens if the CO-OP time-line changes as a result of State Department of Insurance (DOI) concerns?	**A7:** Consistent with recommendations of the CO-OP Advisory Board, CO-OPs should begin discussions with the State DOI as soon as possible and prior to submitting an application in order to be able to provide solvency information as required in the application and comply	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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		with any State requirements that will be essential to formation, operation, and licensure of the CO-OP. Successful applicants will have three years from the first drawdown of Start-up Loans to work with their State DOI to become licensed in order to offer qualified health plans. Successful applicants will be unable to draw down solvency loan funds until such funds are required by the State DOI to complete the licensure process.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q8:** Would the standard in the Final Rule that two-thirds of contracts must be in the individual or small group markets, prevent a CO-OP from offering coverage to large groups or medical groups or hospitals that want to offer the coverage to their employees? Is a Medicaid or Medicare contract counted as one contract?	**A8:** Under the Final Rule, as long as two-thirds of the policies and contracts issued by a CO-OP in each State are qualified health plans in the individual or small group markets, the CO-OP is not prevented from offering coverage to large groups or medical groups that want to offer coverage to their employees. Each insurance policy or contract that an issuer sells constitutes a single activity regardless of the group size. For example, a firm of 40 insured workers and an individual Exchange enrollee each count as single activity. Therefore, a Medicaid or Medicare contract or an employer group contract would be counted as one single activity.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q9:** Can a business plan and budget include funding for private purchasing	**A9:** According to the Funding Opportunity Announcement, the costs of establishing private purchasing councils as provided for in section 1322(d) of the	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	council administration and governance activities?	Affordable Care Act may be considered start-up costs.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q10:** How is "part of State or local government and …medical practice groups" defined in the Final Rule? Would a hospital that is a separate, private, not-for-profit entity that provides training for medical students of a State university medical school be prohibited from sponsoring a CO-OP? Could such a hospital or related entity sponsor a CO-OP so long as the chief executive and board members are not shared?	**A10:** Consistent with the Final Rule, a private, non-profit hospital that provides training to State university medical students or residents, but does not receive funding other than as payment for services from an instrumentality of a State or local government may sponsor a CO-OP. The Final Rule clarifies that a CO-OP may receive limited grants (less than 40% of its total funding, excluding CO-OP loans) and other funding from a State or local government as long as the CO-OP or its sponsor is not controlled by a governmental entity.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q11:** Would a conversion to a for-profit entity be prohibited in all situations? What if the CO-OP Members voted in favor of such a conversion if	**A11:** Under the Final Rule, a CO-OP conversion to a for-profit entity is prohibited in all circumstances.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	it meant that coverage would be preserved? What happens if, after several years of operations, the CO-OP needs additional financial support and the most suitable alternative is private equity? Would a conversion be prohibited?				
Consumer Operated and Oriented Plan (CO-OP) Program	**Q12:** Is the (Treasury rate minus 1%) a fixed or adjustable rate for the loan repayment?	**A12:** According to the Funding Opportunity Announcement, Start-up Loan recipients will be charged an interest rate equal to the average interest rate on marketable Treasury securities of similar maturity minus 1 percentage point (but no less than 0%), at the time of award. This interest rate will be determined at the time of the award and remain fixed for the life of the loan. Similarly, Solvency Loan recipients will be charged an interest rate equal to the average interest rate on marketable Treasury securities of similar maturity minus 2 percentage points (but no less than 0%), at the time of award. This interest rate will be determined at the time of the award and remain fixed for the life of the loan.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and	**Q13:** Can a person	**A13:** Under the Final Rule, a member of	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/F

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
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Oriented Plan (CO-OP) Program	that is a member of an existing health cooperative that is an existing licensed issuer be on the Board of Directors (BOD) of a CO-OP or otherwise involved with the governance of that CO-OP?	an existing health cooperative that is a licensed issuer may serve on the BOD of a CO-OP or otherwise participate in the governance of a CO-OP if the member is not a representative of the existing health cooperative. Therefore, the member cannot participate on the CO-OP's BOD if he or she is an employee of the existing health cooperative or otherwise serves as a "representative" of the organization. A "representative" means an individual who stands or acts for an organization or group of organizations through a formal agreement or financial compensation such as a contractor, broker, lobbyist, official, or employee. The member must not serve in a position that would create a conflict of interest or allow the existing health cooperative to exert undue influence on the governance of the CO-OP.	11, 2011		unding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q14:** Can an employee from a current health insurance issuer also be an employee for a CO-OP?	**A14:** Consistent with the Final Rule, an employee may work for both a current health insurance issuer and a CO-OP, provided that the employee does not serve in a position of leadership or management for either organization that would create a conflict of interest or allow the current health insurance issuer to exert undue influence on the governance or activities of the CO-OP.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP)	**Q15:** After receiving the Letters of Intent	**A15:** Because the loan award process is competitive, CMS does not anticipate	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Program	(LOI) to apply for CO-OP loans, will CMS be releasing this information publicly?	publicly posting the names or locations of organizations that submit a Letter of Intent (LOI).			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q16:** Will CMS approve Start-Up Loan modifications necessary to satisfy the capital requirements associated with unexpected rapid growth or high enrollment?	**A16:** Consistent with the FOA, applicants should estimate their funding needs as accurately as possible in the business plan submitted as a part of the application. Applicants should not assume that loan modifications will be available to provide additional funding.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q17:** Will CMS allow applicants to submit detailed budgets only for the limited Start-Up period and less detailed forecasts for the periods after that?	**A17:** Consistent with the FOA, the budget and budget narrative must account for all uses of Start-Up Loan funds and cover the full period through which start-up funds are expended. The budget template attached to the funding opportunity announcement (FOA) is intended to be a sample of what CO-OP applicants should provide with their business plans. Applicants are expected to submit a budget plan for Start-Up and Solvency Loans with as much specificity as is feasible, with the expectation that CO-OPs will be updating their business plan as they become operational.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q18:** What would preclude a CO-OP from offering	**A18:** As described in Section 1322(c)(6) of the Affordable Care Act, an entity cannot be a qualified nonprofit health	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	insurance prior to 2014?	insurance issuer unless it "does not offer a health plan in a State until that State has in effect (or the Secretary has implemented for the State) the market reforms required by part A of title XXVII of the Public Health Service Act."			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q19:** Can an organization partner with an existing health insurance issuer to develop a CO-OP?	**A19:** As a statutory requirement under section 1322(c)(2)(A)the Affordable Care Act, if an organization is a health insurance issuer that was in existence on July 16, 2009, a related entity, or any predecessor of either (pre-existing issuer), that organization is not eligible for loans under the CO–OP program and cannot become a CO–OP. The Final Rule also prohibits pre-existing issuers from sponsoring a CO-OP.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q20:** Will CMS allow a Third Party Administrator develop a CO-OP?	**A20:** Consistent with the statute and Final Rule, a Third Party Administrator may develop a CO-OP unless the Third Party Administrator was also a licensed health insurance issuer on July 16, 2009.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q21:** If CMS is unlikely to fund applicants with overlapping service areas and two applicants submit Letters of Intent (LOI) to apply for funds, is the first applicant's application held until	**A21:** The statute permits the funding of multiple CO-OPs in any State, provided that there is sufficient funding to capitalize at least one CO-OP in each State. Consistent with the FOA, we expect applications to be reviewed within approximately 75 days of notice of an application being complete. Accordingly, applications will be evaluated on their own merits, and awards will be made in the time-table	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	the second applicant's application is reviewed?	outlined in the FOA. Final award decisions will be made by a CMS program official. In making these decisions, the CMS program official will take into consideration: recommendations of the external reviewers; reviews for programmatic compliance; the reasonableness of the size of the loan request and anticipated results of funding the application; ability to repay the loan, and the likelihood that the proposed project will result in the benefits expected.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q22:** Does the prohibition in the statute on provider rate setting by a private purchasing council prevent CO-OPs from arranging for their provider contract rates to be used by other CO-OPs for out-of-network care?	**A22:** Under the statute, CO-OPs will be allowed to establish private purchasing councils. As described in the statute, private purchasing councils may not "set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers," and relevant antitrust law continues to apply. However, CO-OPs "may establish a private purchasing council to enter into collective purchasing arrangements for items and services other than those directly with health care providers that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services." CO-OPs should work with State	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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		insurance regulators to establish service areas that meet all applicable State laws.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q23:** Can the CO-OP use a management services organization to provide services for the benefit of the CO-OP, including providing executives for the organization?	**A23:** Consistent with the Final Rule, a CO-OP must demonstrate that the management is controlled by the CO-OP members and is accountable to them. Applicants must show how they will achieve this accountability when transitioning from the Formation Board to Operational Board. Boards are permitted to include experts who are not plan members in order to obtain knowledge in areas such as finance, actuarial functions, and medical management.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q24:** Does CMS have any objection to a CO-OP paying reasonable fees to the members of the formation board of directors (BOD) or to the members of the operational board of directors (BOD)?	**A24:** The statute, Final Rule, and FOA do not prohibit reasonable compensation. Applicants should consider that salaries will affect the size of the loans and premium rates in their business plan, which will be evaluated to ensure that they are viable in the CO-OP's target market.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q25:** Does the 80% individual/small group Medical Loss Ratio (MLR) requirement under the Affordable Care Act is, apply to CO-OPs, especially in the early years of their	**A25:** Under the statute, the Medical Loss Ratio (MLR) standards that appear in Section 2718 of the Public Health Service Act apply to CO-OPs. These rules include a "credibility adjustment" when the insurer's medical loss ratio for a market within a State is based on less than 75,000 people enrolled for an entire calendar year. The credibility	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	development?	adjustment, recommended by the National Association of Insurance Commissioners (NAIC) and adopted in the regulation, addresses the statistical unreliability of experience based on a small number of people covered. In addition, consistent with NAIC recommendations, certain insurers that have newly joined the insurance market may be able to delay reporting their medical loss ratio until the next year. When 50% or more of an insurer's premium income accounts for policies that have not been effective for an entire calendar, they are eligible to delay reporting until the following year. A fact sheet on MLR standards is available here: http://www.healthcare.gov/news/factsheets/medical_loss_ratio.html.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q26:** Does CMS determine if a CO-OP is tax-exempt at the State level?	**A26:** Under the statute and Final Rule, an applicant and a CO-OP must be "organized under State law as a nonprofit, member corporation," which is defined as "a nonprofit, not-for-profit, public benefit, or similar membership entity organized as appropriate under State law." State tax-exempt status is not an eligibility criterion; it is possible that an organization may be a nonprofit organization but not tax-exempt under State law.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP)	**Q27:** Does an existing non-profit	**A27:** First, as a statutory requirement under the Affordable Care Act, a health	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Program	entity have to form a separate entity to apply for funds and become a CO-OP?	insurance issuer that was in existence on July 16, 2009 cannot sponsor a CO-OP. Under the Final Rule, the applicant must be the entity that will eventually become a CO-OP. Unless the sponsor wants to become a CO-OP, it should form a separate entity.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q28:** Can a CO-OP be founded by a consumer-run nonprofit self-insured Multiple Employer Welfare Arrangement (MEWA) that does not have an insurance license, but that is currently licensed in its domiciliary state as a non-profit, self-funded MEWA?	**A28:** Under the statute and Final Rule, entities not licensed as issuers on July 16, 2009 are permitted to apply. If a MEWA was licensed as an issuer in a State on July 16, 2009, it cannot receive a loan under the CO-OP program.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q29:** If an applicant is applying to operate in multiple States, are separate loan applications required? If an application covers more than one State, can the $100,000 available for preparing the business plan and	**A29:** Consistent with the Final Rule and FOA, submitting multiple applications for CO-OPs operating in multiple States depends on the management team and governance of each CO-OP. Separate loan applications can be submitted if the CO-OPs are independently organized under State law, the management teams differ, or the CO-OPs are independent and governed by separate boards of directors by State but share the same sponsor. An applicant intending to	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	feasibility study be multiplied by the number of States?	create a single CO-OP that operates in more than one state need only submit a single loan application. The FOA specifies that, for applicants "approved to operate in more than one State, an additional $50,000 attributable to the cost of preparing feasibility studies and business plans per additional State in which the applicant is approved to operate will be considered eligible costs for Start-Up Loans for up to four additional States amounting to a maximum of $300,000."			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q30:** We anticipate filing as an applicant for two States initially. Each of these States will have a separate legal entity. Should we anticipate making two applications, even though we anticipate sharing administrative and management functions between the two legal entities? If we do file two applications, how could we best reflect this in the budget narrative and forms?	**A30:** If the applicant intends to create a single CO-OP that operates in more than one State, it need only submit a single loan application. On the other hand, if the two entities will be functioning as separate CO-OPs with separate governing boards but are sharing some services in common, an applicant filing for a CO-OP in two States should file two applications. The application should indicate the names and locations of the applicants sharing services in the project narrative. The budget narrative should clearly describe how expenses for shared services will be allocated between the two applicants.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Consumer Operated and Oriented Plan (CO-OP) Program	**Q31:** Which parts of our application can we mark proprietary to protect the identity of potential managers and other sensitive information such as enrollment strategy? Are there specific areas that we may or may not designate as confidential?	**A31:** In accordance with the Department's Freedom of Information Act (FOIA) implementing regulation at 45 C.F.R. § 5.65(c), you may designate part or all of the information you submit as exempt from disclosure under Exemption 4 of the FOIA if you believe the information is commercial or financial information that is confidential or privileged. If there is a FOIA request for your submitted information, we will follow the pre-disclosure notification procedures found at 45 C.F.R. § 5.65(d)-(e) to seek your input on the applicability of Exemption 4 before disclosure is made. If the information has previously been published or made generally available to the public, it will not be considered confidential or privileged for purposes of Exemption 4. For more information on the applicability of Exemption 4, please visit http://www.justice.gov/oip/foia_guide09/exemption4.pdf.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q32:** Can interest be earned on Solvency Loans awarded under the CO-OP program?	**A32:** The statute, Final Rule, and FOA require that reserves are held in appropriate accounts structured and invested in compliance with standards approved by State insurance regulatory agencies.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q33:** Is there any limitation on using the infrastructure	**A33:** Neither the statute nor the Final Rule restricts loans to only lines of business operating in the Exchanges.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	created with CO-OP Start-Up or Solvency-Loans to serve non-exchange business?	CO-OPs are further required to offer plans "in every individual market Exchange that serves the geographic regions in which the organization is licensed and intends to provide health care coverage," and, if the CO-OP serves the small group market, to offer plans "in each SHOP that serves the geographic regions in which the organization offers coverage in the small group market." The Final Rule requires that "at least two-thirds of the policies or contracts for health insurance coverage issued by a CO–OP in each State in which it is licensed must be CO–OP qualified health plans offered in the individual and small group markets."			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q34:** If an individual has family coverage through the CO-OP (either through the individual's employer or the individual's purchase of a non-group policy), are the individual's dependents (e.g. spouse) also members with the right to vote and serve as a director?	**A34:** The Final Rule defines a member as an "individual covered under health insurance policies issued by a loan recipient." However, voting rights are limited to members over 18 years old. This definition of "member" does not permit the plan to exclude adult dependents (e.g. spouses) from governance because every adult covered by the CO OP must be eligible to vote and serve on the board of directors in order to ensure that decisions are made in the best interest of all covered lives.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP)	**Q35:** Can the Solvency Loans be	**A35:** As stated in the FOA, applicants should request the total amount they	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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Program	requested over a ramp-up period (i.e. 2014 through 2016)?	anticipate requiring during the life of the loan. However, as further stated in the FOA, "CMS anticipates that Solvency Loan recipients may need to draw down the loan in multiple phases."			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q36:** Can applications be supplemented after submission?	**A36:** No. As required in the FOA, all loan applications must be submitted electronically as complete and be received through http://www.grants.gov by 11:59 p.m. Eastern Time on October 17, 2011, or by 8:00pm Eastern Time on the quarterly application due dates thereafter: January 3, 2012, April 2, 2012, July 2, 2012, October 1, 2012 and December 31, 2012. It is important to make sure that applications are complete at the time of submission according to the requirements set forth in the FOA. Appendix A on page 55 of the FOA serves as an organizational tool to assist the applicant in preparing a complete application package. Applicants are strongly encouraged not to wait until the due date to submit their application package in case of technical or other unforeseen difficulties. Applicants should register on grants.gov at least one month prior to the due date to be sure that they have registration numbers and other information needed to submit an application Incomplete or late applications will not be considered for award in that submission round.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and	**Q37:** Can the	**A37:** As indicated in the FOA, an	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Oriented Plan (CO-OP) Program	application ask for a range of funding (minimum/max with two different plans for growth?)	applicant should submit its most accurate projection of its funding needs based on its expected growth trajectory as reflected in its business plan.	11, 2011		unding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q38:** How long does the grants.gov registration process take if our organization has never used this process before?	**A38:** The time required to complete the registration process varies by applicant and it is possible that it may take over a month. Therefore, we strongly encourage you to start this process as early as possible. In order to use grants.gov you will be required to have an Employee Identification Number (EIN) and a Data Universal Numbering System (DUNS) number; you also will need to register with the Central Contractor Registration (CCR) database. For specific information about these various numbers and databases please go to http://www.grants.gov/applicants/applicant_faqs.jsp.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q39:** The FOA encourages applicants to secure private support, including but not limited to, committed funding, committed in-kind support, letters of intent from key stakeholders or partners, and letters of support from key	**A39:** Yes. The funding opportunity announcement states that an applicant should include any evidence of private support (which includes letters of support from key community leaders) as an attachment when submitting a completed application on grants.gov. All materials should be submitted with the application to grants.gov. If letters of support for an applicant are sent directly to CMS, we cannot guarantee that they will be considered as part of	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	community leaders. Do letters of support from key community leaders need to be submitted with my application?	that application.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q40:** The Funding Opportunity Announcement lists "Evidence of Private Support" as a required document under the Start-up Loan and Solvency Loan Application Check List on page 56. However, the Review Criteria listed on page 40 of the FOA states that "Evidence of Private Support" is a statutory preference and not a requirement. If an applicant does not have any evidence of private support, do they need to provide this document?	**A40:** No. As stated in the Amended FOA released on December 9, 2011, evidence of private support is a recommended document. Evidence of private support should only be provided if an applicant has private support such as committed funding, or committed in-kind provision of services. As discussed in Q39, evidence of private support also includes letters of intent from key stakeholders (e.g., provider groups) to participate in the CO-OP or its formation, and/or letters of support from key community leaders. Applicants who do not have private support should indicate this in their application.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q41:** Who is conducting the external review process for CO-OP	**A41:** To assist CMS in awarding CO-OP loans, we have obtained services from Deloitte Consulting, LLP to establish, and manage qualified expert,	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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	applications?	objective technical panels responsible for reviewing applications and providing recommendations to CMS staff. The technical review panels review all applications to determine applicant eligibility. As stated in the FOA, the final award decisions are made by CMS program officials with private insurance expertise and who are walled off from CMS CO-OP program staff.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q42:** How many applications did CMS receive for the CO-OP program on October 17th and January 3, 2012 and what States do these applications cover?	**A42:** Consistent with established Departmental policy in the administration of a competitive award process, CMS does not anticipate publicly posting the names or locations of organizations that submit an application. This information will be posted for successful applicants that receive loans. We can say that applications received reflect proposals to operate in most states, with multiple applications for a number of states. However, applicants should keep in mind that all materials submitted to CMS are subject to the Freedom of Information of Act (FOIA), 5 USC § 552. Certain information in the materials may be exempt from release (for example confidential business information and personal privacy information), as outlined in the FOIA and in the Department's FOIA regulation. Individuals who wish to submit a FOIA request for CMS records	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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		may do so by utilizing the following link to the CMS FOIA webpage: http://www.cms.gov/foia/.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q43:** If a representative of a for-profit health care provider sits on the Board of Directors of a pre-existing Issuer, is the for-profit health care provider barred from sponsoring a CO-OP?	**A43:** No. The health care provider could sponsor a CO-OP as long as the representative of the provider resigns from the Board of Directors of the issuer. The CO-OP board cannot have any members that also represent pre-existing issuers that are a related entity to the for-profit sponsoring organization.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q44:** Can Start-up Loans be used to fund costs associated with clinical functions and/or physical construction of offices and facilities?	**A44:** No. Start-up Loans cannot be used to fund costs associated with construction of facilities, including clinical facilities, nor can Start-up Loans be used for clinical expenses, such as salaries of or payments to treating providers, provider clinical space or administrative staff associated with clinical functions, or clinical equipment. CO-OPs should be self-sustaining, meaning these costs are paid for by member premiums and reflected in the reimbursement to providers. However, start-up funds can be used to develop integrated administrative and clinical IT and to provide other functions typically associated with the business of insurance such as quality improvement and disease management programs.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and	**Q45:** After	**A45:** At the http://www.grants.gov	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Oriented Plan (CO-OP) Program	submitting my application via www.grants.gov - Opens in a new window, I received an error message saying that "one or more of my documents failed to upload." How should I resolve this issue?	website, you will find information about submitting an application electronically through the site. Technical support is available 24 hours a day, 7 days a week [1-800-518-4726 or support@grants.gov]. We strongly recommend that that all applicants register and receive their DUNS number as early as possible. In addition, we strongly recommend that applicants begin the process of uploading the application through www.grants.gov - Opens in a new window as early as possible because technical difficulties in the application submission that cannot be resolved within the deadline may result in your application being denied review until re-submitted in the next application submission cycle. Applicants can submit their applications at any time up to the deadline. In addition, please follow this guidance to ensure that you upload your application successfully: •The applicant must submit all documents electronically in PDF format or Microsoft Excel (Please use Microsoft Office 2007), including all information included on the SF 424 and all necessary assurances and certifications, and all other attachments. •Please upload each required and recommended document from the Start-	11, 2011		unding-Opportunities/coop_foa_faq.html

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		up Loan and Solvency Loan Application Check List as a separate attachment. The checklist can be found on page 55 of the Funding Opportunity Announcement. •Please include a table of contents page with your application that lists all required and recommended documents in your submission. The table of contents should list each attachment with a brief explanation of what the document is and how many pages it contains (including the number of worksheets within an Excel workbook). •Please include a header at the top of each attachment clearly indicating what the document is. For example, the Feasibility Study (a required document) should have a header at the top of each page of the document that says "Feasibility Study" as well as the name of the applicant organization. If a document cannot have a header (i.e. one of the Standard Forms or the resumes) please use a cover page for this attachment indicating what the file is. •Please use a file name for each attachment that indicates what the document is. For example, the Feasibility Study should be saved as "ABC CO-OP. Feasibility Study.PDF" and not saved as "Attachment A." •Please use page numbers for the application and separate page numbers for each Attachment. For example, the			

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		page numbers in the feasibility study should be labeled "Feasibility Study, page •Please do not save files or zipped files that are embedded within a PDF or Excel file. Please save all documents as a separate PDF or Excel file and upload them separately.			
Consumer Operated and Oriented Plan (CO-OP) Program	**Q46:** The Funding Opportunity Announcement lists "Evidence of Nonprofit Status" as a required document under the Start-up Loan and Solvency Loan Application Check List on page 56. What type of evidence is needed to prove that an applicant has obtained nonprofit status in their State?	**A46:** In order to fulfill this requirement, the applicant must submit a copy of the organization's official certificate of organization or similar document, such as articles of incorporation, showing the State or tribal seal that clearly establishes that nonprofit status has been conferred or recognized by the appropriate State department or official. Applicants must submit evidence of nonprofit status that is certified or approved as provided under State law or the entire application will be rejected. Rejected applicants can re-apply in the next round. An application for nonprofit status submitted to the State but that has not been approved and certified by the State is not sufficient.	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html
Consumer Operated and Oriented Plan (CO-OP) Program	**Q47:** Are Multiple Employer Welfare Arrangements (MEWAs) eligible to apply for CO-OP loans?	**A47:** Consistent with the FOA and the Final Rule section 156.510, MEWAs are eligible to apply for a loan under the CO-OP Program if they are not pre-existing issuers and they meet all eligibility requirements. Therefore, if on July 16, 2009, a MEWA was licensed as an issuer in a State and was	FAQ October 11, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Funding-Opportunities/coop_foa_faq.html

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		subject to State law that regulates insurance, it is not eligible to become or sponsor a CO-OP. The laws for MEWAs vary from State to State; accordingly, some MEWAs may be eligible to apply to be a CO-OP and others may not.			
COBRA Continuation Coverage	**Q1:** What is COBRA continuation coverage?	**A1:** The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) amended the Public Health Service Act, the Internal Revenue Code and the Employee Retirement Income Security Act (ERISA) to require employers with 20 or more employees to provide temporary continuation of group health coverage in certain situations where it would otherwise be terminated.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q2:** What is public sector COBRA?	**A2:** Title XXII of the Public Health Service (PHS) Act, 42 U.S.C. §§ 300bb-1 through 300bb-8, applies COBRA requirements to group health plans that are sponsored by state or local government employers. It is sometimes referred to as "public sector" COBRA to distinguish it from the ERISA and Internal Revenue Code requirements that apply to private employers.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q3:** Who has jurisdiction with respect to public sector COBRA?	**A3:** The U.S. Department of Health and Human Services, through the Centers for Medicare & Medicaid Services (CMS) has jurisdiction with respect to the COBRA continuation coverage requirements of the PHS Act that apply to state and local government	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		employers, including counties, municipalities and public school districts, and the group health plans that they sponsor.			
COBRA Continuation Coverage	**Q4:** What is a qualified beneficiary?	**A4:** A qualified beneficiary is an individual who is entitled to COBRA continuation coverage because he or she was covered by a group health plan on the day before a "qualifying event." Depending on the circumstances, the following individuals may be qualified beneficiaries: a "covered employee" (a term that includes active employees, terminated employees and retirees); a covered employee's spouse and dependent children; any child born to or placed for adoption with a covered employee during the period of COBRA coverage; agents; self-employed individuals; independent contractors and their employees; directors of the employer; and, for public sector group health plans, political appointees and elected officials.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q5:** What is a qualifying event?	**A5:** Qualifying events are certain events that would cause an individual to lose health coverage under a group health plan. The type of qualifying event will determine who the qualified beneficiaries are and how long they will be entitled to COBRA coverage.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q6:** What are some examples of qualifying events?	**A6:** The following are qualifying events: the death of the covered employee; a covered employee's	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		termination of employment or reduction of the hours of employment; the covered employee becoming entitled to Medicare; divorce or legal separation from the covered employee; or a dependent child ceasing to be a dependent under the generally applicable requirements of the plan.			
COBRA Continuation Coverage	**Q7:** How long does COBRA last?	**A7:** Assuming one pays all required premiums, COBRA coverage starts on the date of the qualifying event, and the length of the period of COBRA coverage will depend on the type of qualifying event which caused the qualified beneficiary to lose group health plan coverage. For "covered employees," the only qualifying event is termination of employment (whether the termination is voluntary or involuntary) including by retirement, or reduction of employment hours. In that case, COBRA lasts for eighteen months. If the qualifying event is the death of the covered employee, divorce or legal separation of the covered employee from the covered employee's spouse or the covered employee becoming entitled to Medicare, COBRA for the spouse or dependent child lasts for 36 months.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q8:** How is COBRA affected if I am	**A8:** In certain circumstances, if a disabled individual and non-disabled	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-

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	disabled?	family members are qualified beneficiaries, they are eligible for up to an 11-month extension of COBRA continuation coverage, for a total of 29 months. The criterion for this 11-month disability extension is a complex area of COBRA law. We provide general information below, but if you have any questions regarding your disability and public sector COBRA, we encourage you to email us at phig@cms.hhs.gov. In general, the COBRA qualifying event must be a termination of employment or a reduction of the covered employee's employment hours. Second, the covered employee must be determined under title II or title XVI of the Social Security Act to be disabled. Third, the individual must be disabled at some time during the first 60 days of COBRA continuation coverage, regardless of whether the disability started prior to or during that period. Fourth, while the disability must begin within the first 60 days of COBRA coverage, the determination under title II or XVI can be issued any time during the 18-month period of COBRA coverage that began with the qualifying event. Finally, the covered employee must generally notify the plan administrator about the disability determination within 60 days after the date the disability determination is issued, but in no case			Protections/cobra_qna.html

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		later than the end of the 18-month period of continuation coverage that applies to the qualifying event. In addition, the extended period of COBRA ends if there is a final determination under title II or XVI that the individual is no longer disabled. Note that the group health plan is permitted to charge up to 150 percent of the applicable premium for the 11-month extension.			
COBRA Continuation Coverage	**Q9:** What notification requirements apply when there is a qualifying event?	**A9:** Separate requirements apply to the employer and the group health plan administrator. An employer that is subject to COBRA requirements is required to notify its group health plan administrator within 30 days after an employee's employment is terminated, or employment hours are reduced. Within 14 days of that notification, the plan administrator is required to notify the individual of his or her COBRA rights. If the employer also is the plan administrator and issues COBRA notices directly, the employer has the entire 44-day period in which to issue a COBRA election notice.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q10:** When do I have an obligation to notify my plan administrator that I have had a qualifying event?	**A10:** If you become divorced or legally separated from the covered employee, or if a dependent child no longer meets the requirement to be a covered dependent (usually by reaching a specified age), the covered employee or	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		qualified beneficiary is responsible for notifying the plan administrator of the qualifying event within 60 days after the date of the qualifying event.			
COBRA Continuation Coverage	**Q11:** What is the next step in the process once appropriate notice of a qualifying event is given to the health plan administrator?	**A11:** Plan administrators that receive notice of a qualifying event must notify qualified beneficiaries of their right to elect COBRA coverage. Qualified beneficiaries have independent election rights, and therefore they must each be notified. If all the qualified beneficiaries reside at the same address, the plan administrators may either include separate election notices for each qualified beneficiary in a single mailing that is addressed to both the employee and spouse, or send a single notice that clearly identifies all qualified beneficiaries covered by the notice, and explains each person's separate and independent right to elect COBRA continuation coverage. Each qualified beneficiary then has 60 days to decide whether to elect continuation coverage. If the plan administrator knows that there are qualified beneficiaries who do not live at the same address, and knows their addresses, separate election notices must be sent to those qualified beneficiaries. A notice sent to the spouse is treated as a notification to all qualified dependent children residing with the spouse at the time the spouse's notification is sent by the plan	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		administrator. Notices must be provided in person or by first class mail.			
COBRA Continuation Coverage	**Q12:** What does a COBRA election notice include?	**A12:** A notice of COBRA rights generally includes the following information: •A written explanation of the procedures for electing COBRA, •The date by which the election must be made, •How to notify the plan administrator of the election, •The date COBRA coverage will begin, •The maximum period of continuation coverage, •The monthly premium amount, •The due date for the monthly payments, •Any applicable premium amount due for a retroactive period of coverage, •The address to which to send premium payments, •A qualified beneficiary's rights and obligations with respect to extensions of COBRA coverage, and •The bases for early termination of the period of COBRA coverage.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q13:** How do I elect COBRA?	**A13:** Qualified beneficiaries must notify the plan administer of their election according to the instructions laid out in the election notice. Qualified beneficiaries must be given an election period of at least 60 days during which each qualified beneficiary may choose	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		whether to elect COBRA coverage. This period is measured from the later of the date of the qualifying event or the date the COBRA election notice is provided. COBRA coverage is retroactive if elected and paid for by the qualified beneficiary.			
COBRA Continuation Coverage	**Q14: Where do I send my COBRA payments?**	**A14:** The COBRA election notice should contain the address to which premium payments should be sent and should be provided by the employer or group health plan administrator along with the amount of the premium due and its due date.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q15:** How long do I have before I have to submit my first COBRA payment?	**A15:** A group health plan cannot require payment for any period of COBRA continuation coverage earlier than 45 days after the day on which the qualified beneficiary made the initial election for continuation coverage.	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q16:** Once the first payment is made, when do I have to submit payments for all future COBRA premiums?	**A16:** Not including the first premium payments, all other premium payments must be made within 30 days of the due date (due date is set by the group health plan).	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html
COBRA Continuation Coverage	**Q17:** How is COBRA coverage computed and how much will I pay?	**A17:** Usually the beneficiary is required to pay the entire cost of COBRA coverage, although a few employers choose to subsidize COBRA. However, in the likely event that the employer chooses not to subsidize COBRA, the COBRA premium cannot exceed 100 percent of the cost of the group health	FAQ October 19, 2011	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_qna.html

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		plan for similarly situated individuals who have not incurred a qualifying event, including both the portion paid by employees and any portion paid by the employer prior to the qualifying event, plus an additional 2 percent for administrative costs. Please note the employer may charge up to 150 percent for an 11 month disability extension of COBRA coverage. General note: COBRA can be a daunting and complex area of Federal law. If you have any questions or issues regarding public sector COBRA we encourage you to email us at phig@cms.hhs.gov.			
Health Insurance Market Reforms: Withdrawal of Non-Grandfathered Business	**Q1:** If a health insurance issuer's product includes both grandfathered and non-grandfathered business, can the health insurance issuer use the Health Insurance Portability and Accountability Act (HIPAA) product withdrawal (discontinuance) procedures for the non-grandfathered business, but maintain the grandfathered	**A1:** Yes, so long as the issuer meets the guaranteed renewability requirements under HIPAA (implemented in 45 CFR 146.152), including offering substitute coverage for enrollees of the non-grandfathered products.[1] Enrollees of the non-grandfathered products can either be offered a "new" 2014 compliant product or a non-grandfathered product that has been modified to comply with the 2014 provisions. A "new" product is one that has no previous enrollment and does not represent a previous plan with enrollment which is being modified to comply with state or federal requirements or is one which is defined as new by the appropriate state	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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	business related to that product?	regulator. Enrollees of the grandfathered product can maintain that coverage if that coverage continues to be offered and the coverage does not make a change that would cause the product to cease to be grandfathered as provided for under the interim final regulations.			
Health Insurance Market Reforms: Maintenance of Alternative Mechanisms	**Q2:** Given the guaranteed availability requirement in 2014, what does this mean for states with alternative mechanisms?	**A2:** In general, most state high risk pool coverage is not provided through insurance and is not group health plan coverage. Such state high risk pool coverage is not subject to title XXVII of the PHS Act. However, some states, as their state alternative mechanism, require issuers (or certain issuers of last resort) to guarantee the availability of a product or specific benefit design. If the state alternative mechanism is individual market insurance coverage, it is subject to title XXVII of the PHS Act, to the extent that it is not grandfathered. In 2014, individuals enrolled in state high risk pools will have the same rights as others to guaranteed availability of any individual market products offered inside and outside of the Health Insurance Marketplace or Exchange, and states may not prevent individuals from moving to other products or to an Exchange in a state. Note that state high risk pools may continue past 2014. PHS Act section 2702, which requires	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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		guaranteed availability of all products in the individual and small group markets, has rendered section 2741 moot with regard to non-grandfathered plans. Accordingly, beginning in 2014, states will no longer be required to maintain their alternative mechanisms for the purpose of guaranteeing coverage to HIPAA eligible individuals. CMS also will no longer be reviewing the state alternative mechanism for compliance with PHS Act section 2741. States will have the discretion to determine how long beyond January 2014 their state alternative mechanisms can continue to exist or, if it was a "federal fallback" state that did not have an alternative mechanism, whether health insurance issuers in the individual market must continue to offer certain products to HIPAA eligible individuals.			
Health Insurance Market Reforms: Geographic Rating Areas	**Q3:** Will small group market rating be based on employee or employer address? Will this approach apply only to plans offered through the FF-SHOP, or will it also apply to the small group market outside the Exchanges?	**A3:** We intend to propose in future rulemaking that the geographic rating factor and premiums will be based on the employer's primary business location. This would apply both inside and outside of the SHOP. In the context of the FF-SHOP, we intend to propose that an employer generally may have only one SHOP account per state. This limitation would not apply to multi-state employers, however, which will still be able to establish either one SHOP account for all employees (primary	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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		business location will be used for rating purposes) or establish multiple SHOP accounts (primary business location in each state will be used for rating purposes).			
Health Insurance Market Reforms: Geographic Rating Areas	**Q4:** What rating areas should be used for individual market plans if family members live in multiple locations?	**A4:** CMS believes that the location of the primary subscriber should be the rating area used for rating individual market plans, if purchased in the same state, regardless of the location of other individuals covered by the plan.	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html
Health Insurance Market Reforms: Geographic Rating Areas	**Q5:** How many rating factors can an issuer have in a geographic rating area?	**A5:** An issuer can have one geographic rating factor per approved geographic rating area per single risk pool in a state.	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html
Health Insurance Market Reforms: Geographic Rating Areas	**Q6:** Can issuers vary their geographic rating factors within a rating area by product to reflect differences in network efficiency?	**A6:** No. To preserve the integrity of the single risk pool requirement, rating areas must apply uniformly within each market and may not vary by product in that market.	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html
Health Insurance Market Reforms: Geographic Rating Areas	**Q7:** We understand that some issuers need clarification on the rule prohibiting issuers from varying geographic area rating factors by product within a geographic rating area, and made plans to do so based on	**A7:** CMS understands that plans have operated in good faith with respect to these rules prior to the release of the clarifying FAQs (http://www.cms.gov/cciio/resources/factsheets/qa_himr.html). Based on the timing of the release of these clarifying FAQs, CMS acknowledges that the rule could have been clearer with respect to varying geographic rating factors by product within a geographic rating area	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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	network cost differences. Would CMS consider a transitional period during which issuers that vary geographic rating factors on a plan-by-plan basis based on network cost differences would not be found to be out of compliance by CMS, until they make this conforming change?	and understands that issuers may not have sufficient time to adjust their plans as would be necessary to comply with this specific requirement before the deadline for submission of applications to the Federally Facilitated Marketplaces for certification of QHPs. Accordingly, for the 2014 plan or policy year only, issuers with plans subject to the rating rules imposed under the Affordable Care Act will not be found to have violated the Market Rule limitation on geographic rating if they implement geographic rating factors that vary by plan, provided that any variation in geographic rating factor by plan is based only on actuarially justified network cost differences for each geographic rating area. Consistent with the Market Rule final rule and the FAQ, no other variation in geographic rating factor by plan will be permitted. Based on this guidance, all issuers submitting plans to the Federally Facilitated Marketplaces for certification as QHPs will have the opportunity to make adjustments to their plans, as applicable. For those issuers that already have submitted plans to the Federally Facilitated Marketplaces or that will not have time before the deadline for submission to make such adjustments, CMS will provide an			

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		opportunity to make such adjustments during the period established for revising plans to correct any identified deficiencies.			
Health Insurance Market Reforms: Definition of Association Coverage	**Q8:** Can states define coverage sold to individuals and small groups through an association as large group coverage and hence avoid subjecting such coverage to the single risk pool and other requirements of the individual and small group market?	**A8:** No. For purposes of Title XXVII of the PHS Act, including the market reforms, any state law that defines coverage sold to individuals and small groups through an association as large group coverage would be preempted by federal law. As stated in previous guidance[3], the test for determining whether association coverage is individual or group market coverage for purposes of Title XXVII of the PHS Act is the same test that applied to health insurance offered directly to individuals or employers. Coverage that is provided to associations but is not related to employment is not considered group coverage under 45 CFR part 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law.[4] If the health insurance coverage is offered in connection with an association group health plan as defined at section 2791 of the PHS Act, it is considered group health insurance coverage.[5] To the extent an association has any covered members that are small employers, the issuer is subject to the requirements that apply to small group coverage with respect to any small employer in the	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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		association. If the coverage is issued through an association, but not in connection with a group health plan, the coverage is considered individual health insurance coverage. In a "mixed" association where different members have coverage that is subject to the individual market, small group market, and/or large group market rules under the PHS Act, as determined by each member's circumstances, each association member must receive coverage that complies with the requirements arising out of its status as an individual, small employer, or large employer.[6] For example, it is not permissible under the PHS Act for mixed association coverage to comply only with the large group market rules, even with respect to its individual and small employer members.			
Health Insurance Market Reforms: Premium Adjustment When Coverage Becomes Secondary to Medicare	**Q9:** Can an issuer adjust premiums to an individual or small group product when it becomes secondary to Medicare?	**A9:** No. In order to assure consumers have a consistent rate throughout the year, the rules provide that once an individual or employer enrolls in a plan at a set premium rate, the issuer generally may not change that rate during the plan or policy year, and must wait to do so until the plan or policy is renewed. Moreover, premiums may only be set based on index rates and adjustments set forth in PHS Act section 2701 and 45 CFR 156.80, which do not include any adjustment to account for an	FAQ April 26, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html

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		enrollee's additional coverage. The issuer may, however, as consistent with current market practice, offer to replace the individual or small group product with a Medicare supplemental / Medigap plan that has a lower premium, which would be an excepted benefit and, therefore, not subject to the requirements of title XXVII of the PHS Act, provided that it is clear that such offer may be effected only at the option of the enrollee (such that it does not amount to a non-renewal or discontinuance of coverage under the guaranteed renewability requirements) and otherwise complies with applicable federal and state laws and regulations, including the Medicare supplemental health insurance policies requirements set forth in section 1882 of the Social Security Act			
Annual Limit Waivers	**Q1:** A health insurance issuer has received from HHS a waiver of the annual dollar limit requirements pursuant to section 2711 of the PHS Act for a group health insurance product. Can this issuer sell that product to a self-insured grandfathered group	**A1:** Yes, if the group health plan and the health insurance coverage satisfy the criteria below. In the December 9, 2010, CCIIO Supplemental Guidance: "Sale of New Business by Issuers Receiving Waivers," HHS stated that it is permissible for a group health plan that is fully insured with a waiver of the annual limit requirement to purchase a new policy from a different issuer that has also obtained a waiver of the annual limit requirement. The December 9, 2010 guidance was published in light of an amendment to the interim final rule	FAQ February 10, 2012	CCIIO	http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/alw-faq.html

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	health plan that has itself been granted a waiver and wishes to switch from being a self-insured plan to a fully insured plan?	concerning grandfathered health plans. The amendment permits a group health plan to maintain its grandfathered status despite entering into a new insurance contract, 26 CFR 54.9815-1251T(a)(1)(ii), 29 CFR 2590.715-1251(a)(1)(ii), 45 CFR 147.140(a)(1)(ii). The amendment permits a self-insured group health plan to become a fully insured plan while maintaining its grandfathered status, so long as the group health plan is not altered in a way that would violate paragraph (g)(1) of the grandfathering rule. While the December 9, 2010, guidance only addressed the scenario of switching from one fully-insured insurance policy to another, the same policy rationale for permitting the change of insured policies applies to a self-insured group health plan that received a waiver of the annual limits requirement pursuant to section 2711 of the PHS Act and wishes to purchase a new policy from a health insurance issuer that has obtained a waiver of the annual limit requirement for that policy. Accordingly, a self-insured group health plan that has obtained a waiver can purchase a group health policy with a waiver from a health insurance issuer under the following conditions, which			

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		are similar to those established in the December 9, 2010, guidance: 1.In all cases, the plan sponsor must have been offering group health coverage to its employees before September 23, 2010, for which it obtained from HHS a waiver of the annual limits requirement; 2.The issuer from which the group health plan is now obtaining the insured policy must have obtained a waiver from HHS for the newly purchased policy; 3.The annual limits of the new policy may not be lower than the annual limits of the previous policy, except in the situation outlined in #4; 4. The plan sponsor may obtain a replacement policy with a lower annual limit only if other comparable coverage is not available. If a plan purchases a lower annual limit policy due to lack of comparable coverage, this change would cause a loss of status under 45 CFR 147.140(g)(1)(vi)(C), relating to status as a grandfathered health plan. 5. The health insurance issuer must obtain from the plan sponsor an attestation that the criteria outlined above are satisfied, and the attestation			

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		must be accompanied by documentation outlining the terms of the prior coverage. Issuers shall retain this information in accordance with the data retention requirements of the September 3, 2010 and November 5, 2010 annual limits guidance documents. 6. To the extent not superseded here, all prior HHS guidance regarding annual limits waivers continues to apply to the plan and policies described here.			
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q1:** How does the Affordable Care Act help young adults?	**A1:** Before the President signed the Affordable Care Act into law, many health plans and issuers could remove adult children from their parents' policies because of their age, whether or not they were a student or where they lived. The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until the adult child reaches the age of 26. Many parents and their children who worried about losing health insurance after they graduated from college no longer have to worry.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q2:** What plans are required to extend dependent coverage up to age 26?	**A2:** The Affordable Care Act requires plans and issuers that offer dependent coverage to make the coverage available until a child reaches the age of 26. Both married and unmarried children qualify for this coverage. This rule applies to all plans in the individual market and to new employer plans. It also applies to	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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		existing employer plans unless the adult child has another offer of employer-based coverage (such as through his or her job). Beginning in 2014, children up to age 26 can stay on their parent's employer plan even if they have another offer of coverage through an employer.			
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q3:** I'm a young adult under the age of 26 and I'm on my parents plan now, but I'm scheduled to lose coverage soon. How can I keep my health insurance?	**A3:** You have a number of options. First, check with your insurance company. Private health insurance companies that cover the majority of Americans have volunteered to provide coverage for young adults losing coverage as a result of graduating from college or aging out of dependent coverage on a family policy. This stop-gap coverage, in many cases, is available now. Second, watch for open enrollment. Young adults may qualify for an open enrollment period to join their parents' family plan or policy on or after September 23, 2010. Insurers and employers are required to provide notice for this special open enrollment period. Watch for it or ask about it. Finally, expect an offer of continued enrollment for plans that begin on or after September 23, 2010. Insurers and employers that sponsor health plans will inform young adults of continued eligibility for coverage until the age of 26. Young adults and their parents need not do anything but sign up and pay for this option.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q4:** I'm under the age of 26, and I used to be on my parents' plan, but I recently lost this coverage because I graduated from college. Can I get coverage?	**A4:** Yes. Check with your insurance company to see if they will provide that coverage to you now. If not, watch for the special open enrollment period and sign up then.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q5:** Now that the regulation is published, are plans required to immediately enroll eligible young adults in their parents' plan?	**A5:** No. The law says that the extension of dependent coverage for children is effective for plan years beginning on or after 6 months after the enactment of the law – that means plan years beginning on or after September 23, 2010. However, the Administration has urged insurance companies and employers to prevent a gap in coverage for young adults aging off of their parents' policy prior to this effective date. To date, over 65 insurers have volunteered to do so. You should check with your insurance company or employer to see if they are offering this coverage option.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q6:** Will young adults be given a special chance to enroll after September 23, 2010?	**A6:** Yes. For plan or policy years beginning on or after September 23, 2010, plans and issuers must give children who qualify an opportunity to enroll that continues for at least 30 days regardless of whether the plan or coverage offers an open enrollment period. This enrollment opportunity and a written notice must be provided not later than the first day of the first plan or policy year beginning on or after	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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		September 23, 2010. Some plans may provide the opportunity before September 23, 2010			
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q7:** Will young adults have to pay more for coverage or accept a different benefit package?	**A7:** Any qualified individual must be offered all of the benefit packages available to children who did not lose coverage because of loss of dependent status. The qualified young adult cannot be required to pay more for coverage than similarly situated individuals who did not lose coverage due to the loss of dependent status.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q8:** Can plans or issuers who offer dependent coverage continue to impose limits on who qualifies based upon financial dependency, marital status, enrollment in school, residency or other factors?	**A8:** No. Plans and issuers that offer dependent coverage must provide coverage until a child reaches the age of 26. There is one exception for group plans in existence on March 23, 2010. Those group plans may exclude adult children who are eligible to enroll in an employer-sponsored health plan, unless it is the group health plan of their parent. This exception is no longer applicable for plan years beginning on or after January 1, 2014.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q9:** Does the adult child have to purchase an individual policy?	**A9:** No. Eligible adult children wishing to take advantage of the new coverage will be included in the parents' family policy.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens	**Q10:** Will Medicare cover adult children in the same way that private health	**A10: No. The provision does not apply to Medicare.**	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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on Businesses and Families	insurance will?				
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q11:** Are both married and unmarried young adults covered?	**A11:** Yes	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q12:** Are plans or issuers required to provide coverage for children of children receiving the extended coverage?	**A12:** No	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q13:** Why is there a special exception for group plans in existence on March 23, 2010?	**A13:** Our goal is to cover as many young adults under the age of 26 as possible with the least amount of burden. If a young adult is eligible to purchase other employer-based health insurance such as through her job, the law does not require the parent or parents' plan to enroll that child if the parents' plan is a grandfathered health plan (i.e., in existence on March 23, 2010). Of course, all group plans have the option to cover all adult children until the age of 26 or beyond. In 2014, this exception will no longer apply.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q14:** What happens if a young adult under the age of 26 is not eligible for employer-sponsored insurance and both	**A14:** Neither parent's plan can deny coverage.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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	parents have separate plans that offer dependent coverage?				
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q15:** Does the law apply to plans or issuers that do not provide dependent coverage?	**A15:** No. There is no federal requirement compelling a plan or issuer to offer dependent coverage at this time. However, the vast majority of group health plans offer dependent coverage and many family policies exist in the individual market.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q16:** Are insurers doing anything to help young adults prior to the September 23rd implementation date?	**A16:** Secretary Kathleen Sebelius called on leading insurance companies to begin covering young adults voluntarily before the September 23rd implementation date required by the Affordable Care Act. Early implementation would avoid gaps in coverage for new college graduates and other young adults and save on insurance company administrative costs of dis-enrolling and re-enrolling them between May 2010 and September 23, 2010. Many companies have responded including: Blue Cross and Blue Shield of Alabama Blue Cross Blue Shield of Delaware Blue Cross and Blue Shield of Arizona, Inc. Blue Cross and Blue Shield of Florida Arkansas Blue Cross and Blue Shield Blue Cross and Blue Shield of Hawaii Blue Shield of California Blue Cross of Idaho Health Service	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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		Regence Blue Shield of Idaho Wellmark Blue Cross and Blue Shield of Iowa Health Care Service Corporation Blue Cross and Blue Shield of Kansas Blue Cross Blue Shield Association Blue Cross and Blue Shield of Louisiana WellPoint, Inc. CareFirst BlueCross and BlueShield Blue Cross and Blue Shield of Massachusetts Blue Cross and Blue Shield of Kansas City Blue Cross and Blue Shield of Michigan Blue Cross and Blue Shield of Montana Blue Cross and Blue Shield of Minnesota Blue Cross and Blue Shield of Nebraska Blue Cross & Blue Shield of Mississippi Horizon Blue Cross and Blue Shield of New Jersey, Inc. HealthNow New York, Inc. The Regence Group Excellus Blue Cross and Blue Shield Capital BlueCross Blue Cross and Blue Shield of North Carolina Independence Blue Cross BlueCross BlueShield of North Dakota Highmark, Inc. Blue Cross of Northeastern Pennsylvania BlueCross and BlueShield of Tennessee Blue Cross and Blue Shield of Vermont			

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		Blue Cross & Blue Shield of Rhode Island Premera Blue Cross Blue Cross and Blue Shield of South Carolina Blue Cross and Blue Shield of Wyoming Kaiser Permanente Cigna Aetna United WellPoint Humana Capital District Physicians' Health Plan (CDPHP), Albany, New York Capital Health Plan, Tallahassee, Florida Care Oregon, Portland, Oregon Emblem Health, New York, New York Fallon Community Health Plan, Worcester, Massachusetts Geisinger Health Plan, Danville, Pennsylvania Group Health, Seattle, Washington Group Health Cooperative Of South Central Wisconsin, Madison, Wisconsin Health Partners, Minneapolis, Minnesota Independent Health, Buffalo, New York Kaiser Foundation Health Plan Oakland, California Martin's Point Health Care, Portland, Maine New West Health Services, Helena, Mt The Permanente Federation, Oakland,			

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		California Priority Health, Grand Rapids, Michigan Scott & White Health Plan, Temple, Texas Security Health Plan, Marshfield, Wisconsin Tufts Health Plan, Waltham, Massachusetts UCARE, Minneapolis, Minnesota UPMC Health Plan, Pittsburgh, Pennsylvania			
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q17:** I understand that there are tax benefits related to the extension of dependent coverage. Can you explain these benefits?	**A17:** Under a change in tax law included in the Affordable Care Act, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26. This tax benefit applies regardless of whether the plan or the insurer is required by law to extend health care coverage to the adult child or the plan or insurer voluntarily extends the coverage.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q18:** When does this tax benefit go into effect?	**A18:** The tax benefit is effective March 30, 2010. Consequently, the exclusion applies to any coverage that is provided to an adult child from that date through the end of the taxable year in which the child turns 26.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens	**Q19:** Who benefits from this tax treatment?	**A19:** This expanded health care tax benefit applies to various workplace and retiree health plans. It also applies to self-employed individuals who qualify	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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on Businesses and Families		for the self-employed health insurance deduction on their federal income tax return.			
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q20:** May employees purchase health care coverage for their adult child on a pre-tax basis through the employer's cafeteria plan?	**A20:** Yes. In addition to the exclusion from income of any employer contribution towards qualifying adult child coverage, employees may pay the employee portion of the health care coverage for an adult child on a pre-tax basis through the employer's cafeteria plan – a plan that allows employees to choose from a menu of tax-free benefit options and cash or taxable benefits. The IRS provided in recent guidance [(Notice 2010-38)] that the cafeteria plan could be amended retroactively up until December 31, 2010 to permit these pre-tax salary reduction contributions.	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html
Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families	**Q21:** It seems like plans and insurers can terminate dependent coverage after a child turns 26, but employers are allowed to exclude from the employee's income the value of any employer-provided health coverage through the end of the calendar year in which the child turns age 26. This is confusing.	**A21:** Under the law, the requirement to make adult coverage available applies only until the date that the child turns 26. However, if coverage extends beyond the 26th birthday, the value of the coverage can continue to be excluded from the employee's income for the full tax year (generally the calendar year) in which the child had turned 26. For example, if a child turns 26 in March but is covered under the employer plan of his parent through December 31st (the end of most people's taxable year), the value of the health care coverage through December 31st is excluded from the employee's	FAQ June 29, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/adult_child_faq.html

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		income for tax purposes. If the child stops coverage before December 31st, then the premiums paid by the employee up to the time the plan was stopped will be excluded from the employee's income.			
Grant Solicitation	**Q1:** What application forms should be used (e.g. the 424 family of forms)?	**A1:** As outlined on page 9, required forms include: the Application for Federal Assistance (SF-424); Budget Information Non-Construction (SF-424A); Assurances – Non-Construction Programs (SF-424B); Disclosure of Lobbying Activities (SF-LLL); Additional Assurance Certifications; and the List of Key Contacts.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q2:** If the recipient is unable to successfully submit an application through Grants.gov due to recipient IT constraints will a hard copy of the application be accepted?	**A2:** We ask that all applicants utilize the grants.gov process to the extent possible. Applicants that are having technical issues with grants.gov must contact support@grants.gov or call 1 800 518 4726 to access 24 hour assistance. Please retain the provided case number. We ask that all applicants begin the grants.gov process immediately to avoid last minute technical issues. If technical issues persist after contacting grants.gov, please also contact Jacqueline Roche at Jacqueline.Roche@hhs.gov and Gladys Bohler at Gladys.Bohler@hhs.gov.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q3:** How long do States have to spend Cycle 1 grant funds?	**A3:** States have from August 9, 2010 through FFY 2011 (September 30, 2011) to utilize Cycle 1 grant funds (pgs. 5, 6).	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html

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Grant Solicitation	**Q4:** Why does the Governor need to submit a letter of endorsement?	**A4:** We are working closely with the States to implement the Affordable Care Act. We require that the Governor endorse the grant application and the proposed health insurance premium review activities or enhancements to ensure close coordination with all State-based agencies that are involved in insurance oversight and other aspects of the Affordable Care Act implementation in the State (pgs. 7, 10, 18).	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q5:** My State reviews filings on an informational basis only. Is my state eligible?	**A5:** Yes. HHS will provide this grant funding to augment and enhance states' current processes and to provide funding for future enhancements (pgs. 4, 5).	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q6:** How will the Maintenance of Effort (MOE) be certified? Would a statement in the application be sufficient?	**A6:** A statement in the application is sufficient to satisfy the MOE requirement.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q7:** What are the necessary qualifications to serve as the Principal Investigator/Project Director on Cycle I grants?	**A7:** HHS understands the variation among States regarding how they organize insurance departments. The Project Director should be the Associate Commissioner (or equivalent) of the health bureau (or division) or the Commissioner.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q8:** To whom should we address the letter of support from the Governor to?	**A8:** The letter of support can be addressed to: The Honorable Kathleen Sebelius	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html

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		Secretary, Department of Health & Human Services 200 Independence Avenue, SW Washington, DC 20201 This letter should be included as part of the application package submitted on grants.gov and should not be submitted separately.			
Grant Solicitation	**Q9:** Can a state submit an application if the budgeted cost is in excess of $1 million, as long as they do not seek more than $1 million for the grant award?	**A9:** The submitted budget must be for no more than $1 million. States are permitted to discuss proposed activities that are budgeted for more than $1 million as long as the proposed budget does not exceed $1 million. Grant funded activities must be outlined clearly in the budget and work plan for grant reporting and monitoring purposes.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q10:** If my state believes that it will not be able to spend $1 million during the period of the first grant cycle, is it precluded from applying for a grant?	**A10:** No. A state is not obligated to submit a budget that totals $1 million in order to receive a grant. It can submit a budget for a lesser amount if it believes that it will only be able to spend that amount. In this situation, assuming all other conditions for a grant are met, the state would receive a $1 million grant with the award being conditioned on the State's agreement to roll excess funds into the following cycle and to return any funds that are unobligated by the end of FY 2014.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q11**: If my state is not able to expend $1	**A11:** Yes, requests for no cost extensions at the end of the project	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html

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	million dollars in the allotted budget period are we eligible for a no-cost extension to extend the project period for Cycle I independently of applying for grants in a subsequent cycle?	period will be considered for States as justified for Cycle I grants. States are also permitted to roll grants funds forward to subsequent grant cycles; however the use of funding must be in compliance with the terms in conditions dictating the subsequent grant cycle.			
Grant Solicitation	**Q12:** Is a state required to make recommendations that a plan not be able to participate in an exchange before 2014?	**A12:** Cycle 1 Grants do not require this recommendation.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q13:** Will there be a template for state submission of data and will states be able to assist in the development of that template?	**A13:** There will be a data template provided for the submission of data as outlined in the Special Terms and Conditions of the award. The Office of Consumer Information and Insurance Oversight (OCIIO) will provide technical assistance and collaborate with States on all data reporting requirements under the grant.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q14:** How do I tell if my state has an EBIZ/ account?	**A14:** The Central Contractor Registration (CCR) database can be searched to determine if the recipient is registered. Registration in CCR is required before an organization can register in Grants.gov When an Authorized Organization Representative (AOR) registers with Grants.gov; the	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html

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		EBIZ Point of contact (POC) will receive an email notification. (pg 8)			
Grant Solicitation	**Q15:** On page 20 of the FOA, language is included that indicates that all grant budgets must include some funding to facilitate participation on the part of individuals who have a disability or long-term illness and their families, is this requirement meant to apply?	**A15:** Applicants will not be penalized if this requirement as outlined in the FOA is not addressed.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q16:** Can States collaborate on the development of Data Centers?	**A16:** Collaboration among States is allowed for Cycle 1 grants. If States anticipate establishing arrangements with other State partners, the consortium activity should be reflected in the grant applications when submitted.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q17:** Will the States be required to continue reporting to the Secretary if funding is not continued for this program?	**A17:** Reporting obligations are for the grant period established in the Notice of Grant Award for the Cycle I Premium Review Grant. Additional federal regulations will be issued later in FFY 2010 regarding the annual process for rate review.	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q18:** Can the work plan be submitted as an attachment?	**A18:** Yes, the work plan can be submitted as part of the appendix materials	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Grant Solicitation	**Q19:** Can a State	**A19:** Yes, we encourage the submission	FAQ June 7,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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	send their rating law methodology as an attachment?	of as much information as necessary to understand the current rate review process. Detailed methodologies can be submitted as part of appendix materials.	2010		iles/premium_review_qa.html
Grant Solicitation	**Q20:** Do attachments count against the 15 page limit?	**A20:** Attachments do not count against the 15 page limit (p 9).	FAQ June 7, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/premium_review_qa.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q1:** Will the application deadline be extended as a result of the modified application process?	**A1:** No, the deadline is July 7th, 2010 at 11:59 p.m. Eastern Daylight Time.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q2:** How will we know if our application has been received by the Office of Consumer Information and Insurance Oversight staff?	**A2:** The Office of Consumer Information and Insurance Oversight will confirm that the application has been received as submitted within 24 hours, or the next business day.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q3:** What if a state has an ongoing issue with obtaining the Central Contractor Registry (CCR) number or the correct DUNS number?	**A3:** All applicants must have documentation that includes a case number from CCR or DUNS if delays are experienced in obtaining the required CCR or DUNS number.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html

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Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q4:** Which application forms are required for the grant application (e.g. the 424 family of forms)?	**A4:** The required mandatory forms include (as outlined in the Funding Opportunity Announcement and other guidance posted on Grants.gov): •The Application for Federal Assistance (SF-424); •Project/Performance Site Location(s) •Assurances – Non-Construction Programs (SF-424B); •Project Abstract •Project Narrative Attachment Form •Objective Work Plan-an applicant is permitted to use the Grants.gov work plan or submit a work plan as an attachment to the application. •Budget Narrative Attachment Form; •Disclosure of Lobbying Activities (SF-LLL); •List of Key Contacts; and •The Attachments form (to submit required attachments and supplemental information. Applicants should begin with the Application for Federal Assistance (SF-424 form), however application materials do not have to be submitted in the exact order outlined on page 26 of the Funding Opportunity Announcement. Note: There is not a requirement under this grant program to provide forms beginning with "RR". The correct family of forms is as listed above	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html

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Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q5:** On the "Check-Off List" provided on pg. 26 there is no mention of the "Project/Performance Site Location(s)" form, however this form is provided in the Mandatory Forms Box on the Grants.gov Grant Application Package. Where does this form fit with the full package and the order of the forms to be submitted?	**A5:** The "Project/Performance Site Location(s)" form is required. Additionally, pg. 26 provides a recommended sequential order for submitting the required documents; the applicant can submit the "Project/Performance Site Locations(s) form along with the other Standard Forms (SF).	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q6:** The link provided on pg. 9, 1. Cover Sheet and Standard Forms: V. Additional Assurances and Certifications: http://apply.grants.gov/forms/sample/SSA_AdditionalAssurances-V1.0.pdf is not operational; please clarify the required submissions regarding Additional Assurances.	**A6:** Regarding Additional Assurance Certifications, an applicant is only required to submit form SF 424B: Assurances-Non-Construction Programs (iii). The List of Key Contacts also outlined in section v. is also required.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer	**Q7:** On the	**A7:** A letter of support is required from	FAQ July 1,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	Application Cover Sheet and Check-off list (pg 26) "Required Letter of Support and "Memorandum of Agreement" are both included as required. What is the "Memorandum of Agreement" requirement?	the Governor. Applicants must also attest that grant funds will not be used to supplant existing rate review activities (maintenance of effort requirement, pg. 7). There is no requirement for a Memorandum of Agreement as outlined on pg. 26.	2010		iles/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q8:** Please clarify the required Applicant's Application Cover Letter and the Application Cover Sheet (Attachment C). Can they both be submitted as an attachment?	**A8:** An applicant must provide a cover letter including all the information outlined on page 10 per section 3. Applicant's Application Cover Letter. The applicant can include the information provided on page 25 (application cover sheet) within the Application Cover Letter, or submit a separate Application Cover Sheet as outlined on page 25. Both options are acceptable and both documents can be submitted as an attachment.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q9:** To whom should the Application Cover Letter be addressed?	**A9:** The application cover letter may be addressed to the Office of Consumer Information and Insurance Oversight (OCIIO).	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer	**Q10:** Is there a	**A10:** There is not a standardized form	FAQ July 1,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	standardized form for the timeline?	for the timeline. The timeline may be submitted as an attachment to the application.	2010		iles/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q11:** How do we fill out the mandatory document "Disclosure of Lobbying Activities" if we do not have any lobbying activities to disclose?	**A11:** The Lobbying Form has yellow mandatory fields that require the applicants to enter data. If the applicant institution does not engage in Lobbying activities they can respond to the section Fields #4, #6, and #11 and respond with an N/A for Section Fields 10a & 10b.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	**Q12:** Should the documents that are submitted as attachments to Grants.gov be in PDF or Word format?	**A12:** Grants.gov and the Office of Consumer Information and Insurance Oversight will accept Word or PDF attachments. However, should an applicant submit an application and receive an error message regarding the attached documents the first troubleshooting response from OCIIO is to convert the Word attachment into a PDF attachment and then to resubmit the application. Note: Grants.gov requires each attached file to have a unique file name.	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html
Office of Consumer Information and Insurance Oversight Affordable Care Act	**Q13:** Can you describe the method by which funds will be disbursed to the	**A13:** Grant funds are disbursed on an ongoing basis to the state upon receipt and approval of a payment request. More detailed instructions for	FAQ July 1, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/grant_proposal_review_qa_7-1-2010.html

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Grants to States for Health Insurance Premium Review-Cycle I Q & As for Grant Proposals	States if a grant application is approved?	submitting payment requests and the process of approval will be provided in the award letter and the grant terms and conditions.			
Rate Review Training	**Q1:** Should all States participate in the rate review training**?**	**A1:** All States are strongly encouraged to participate in the rate review webinars prior to the September 1, 2011, start date of the Rate Review Program. The training provides all States with information about accessing rate review data submitted by issuers for use in their States via the Health Insurance Oversight System (HIOS). Additionally, the training includes procedures and requirements for entering State rate review determinations in the HIOS system.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training	**Q2:** Do issuers need to take the training now if they do not anticipate having any rate increases above the subject to review threshold in 2011?	**A2:** The new federal rate review reporting requirements take effect on September 1, 2011. Issuers offering products in the individual and small group markets should take the training prior to this date to ensure compliance with the new reporting requirements. Additionally, CMS is conducting ongoing user group calls with issuers in August and September. By taking the training now, issuers will have the opportunity to follow up with CMS via the user group calls on any questions about the program The webinar trainings will remain posted on the CMS training portal after	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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		September 1st to give issuers access to the webinars as a reference after the start date of the program.			
Rate Review Training	**Q3:** Which issuer or State staff should take the training?	**A3:** There are no restrictions on the type of issuer or State staff that may take the training, and there is no requirement that staff taking the training must be registered HIOS users. Both the issuer and State trainings provide an overview of the rate review program, including important information on program policies and reporting requirements. This information may be useful to a wide range of staff, including those not registered in HIOS.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training	**Q4:** If an issuer or State has multiple people who want to take the webinar training, do they have to register individually?	**A4:** Yes, each person, including contractors, must register individually for the webinar training by going to following links: Issuer Training: https://webinar.cms.hhs.gov/ratereviewissuers/event/registration.html - Opens in a new window State Training: https://webinar.cms.hhs.gov/ratereviewstates/event/registration.html - Opens in a new window	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training	**Q5:** May actuarial contractors register for HIOS and/or the webinar training?	**A5:** Yes, actuarial contractors may register for both HIOS and the webinar training if they are working on rate review matters with a health insurance issuer or State regulator. If contractors wish to register for HIOS, the issuer or State regulator must register on the	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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		contractor's behalf by adding the contractor to the list of HIOS registrants it sends to CMS. If contractors wish to register for the webinar training, contractors must register themselves via one of the training registration links above. When registering for the webinar training, contractors must respond to the contractor questions on the registration page. These questions require contractors to confirm they are under contract with an issuer or State, and to provide contact information (name, address, and email address) for the issuer or State for verification purposes.			
Rate Review Training	**Q6:** What if I register for the wrong training by mistake or decide not to take the training after I register?	**A6:** After you register for the training, there is no requirement that you actually complete the training, and you are not required to notify CMS that you are not taking the training. Once registered, you may view any of the training webinars available for issuers or State regulators, so you don't need to be concerned about registering for the "wrong" training.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: User Group Calls Rate Review Training Webinars and Registration Information	**Q7:** What is the format of the User Group Calls?	**A7:** During the User Group Calls, CMS staff will answer questions emailed to RateReview@hhs.gov that were received throughout the week, and also will answer questions in real time that are emailed to RateReview@hhs.gov during the calls. CMS encourages issuers and States to email questions to RateReview@hhs.gov well in advance	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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		of the User Group Calls to allow CMS to formulate a thorough response. CMS requests that the email identify the call (date and time) on which the questioner would like CMS to answer the question. Issuers and States are not required to listen to the User Group Calls. The User Group Calls are intended to supplement the webinar training by addressing rate review questions submitted to CMS via email before and during the calls. CMS will not use the User Group Calls to present new training material.			
Rate Review Training: User Group Calls Rate Review Training Webinars and Registration Information	**Q8:** Will CMS post a transcript or audio link of the User Group Calls?	**A8:** CMS will periodically post Frequently Asked Questions (FAQs) that include the questions addressed during the User Group Calls. The FAQs will be posted on CMS' website at: http://cms.gov/cciio/programs/marketreforms/rates/index.html	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: HIOS	**Q9:** What are the differences between the issuer submitter and attester roles in HIOS?	**A9:** Only a submitter may submit a new Preliminary Justification record in HIOS and only an attester may attest to a submitted Preliminary Justification record in HIOS. A single HIOS user may be registered as both a submitter and attester. Companies may make these designations at their own discretion and may assign multiple users for both roles. In addition to submitting and attesting to Preliminary Justification records in HIOS, issuers may also have to amend	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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		attested records (e.g., if they modify a rate increase while a review is in progress, or if CMS requests supplemental information). Attesters and submitters have the same access to all of the post-attestation functions in HIOS, so either designation may amend attested records. Additionally, both user types receive the same email notifications on each record. Note that all State users have the same HIOS access rights. States are not required to designate an attester or submitter.			
Rate Review Training: HIOS	**Q10:** Is the initial submission of the Preliminary Justification the only type of HIOS submission that requires attestation?	**A10:** Yes. Issuers are only required to submit the Preliminary Justification once for each rate increase, regardless of whether the rate increase changes during the review process. This initial submission of the Preliminary Justification is the only action that requires attestation in HIOS. None of the other follow-up actions (e.g., supplemental material submissions, rate modifications) for submitted records require attestation**.**	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: HIOS	**Q11:** Do issuers have to use their existing Plan Finder submitters and attesters for the submission of rate review reporting in HIOS?	**A11:** No. Issuers may assign different users to these roles in the HIOS rate review module. Note that existing HIOS users still have to register for access to the rate review module.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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Rate Review Training: HIOS	**Q12:** Should issuers include HIOS issuer IDs in the organization field of the registration request?	**A12:** Yes. If issuers have HIOS IDs they should include them. This information will help with processing the registration request.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: HIOS	**Q13:** Can a single registration request include more than one HIOS issuer ID?	**A13:** Yes, registration requests may be made for multiple HIOS issuer IDs to be assigned to a single user. In the registration request, issuers should specify the HIOS issuer IDs that should be assigned to each HIOS user. Users with access to multiple issuer IDs will not need a separate user ID for each issuer.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: HIOS	**Q14:** When will registered HIOS users receive their login information?	**A14:** CMS is currently reviewing and approving user requests. All approved users will receive an email with their login information immediately before the September 1st effective date of the rate review program. No users will be permitted to access or enter data in the rate review system prior to the start of the program.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: HIOS	**Q15:** Can issuers make changes to their HIOS registration requests after they have been submitted to CMS?	**A15:** Yes, issuers can make changes to their registration requests. Issuers should submit a new Excel worksheet with the revised information on all of their requested HIOS users. (This second submission will take the place of the first Excel submission.) Issuers should note in the email that they are resubmitting their request.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training:	**Q16:** How does the	**A16:** State users will receive	FAQ August 22,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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HIOS	email notification process work in HIOS?	notification emails each time an issuer attests to a record in HIOS for a rate increase to be implemented in their State. Issuer users will receive a submission status email following the submission of each record (the email will indicate whether the submission passed or failed the automated validation checks). For CMS reviews, issuers will receive an email notification if CMS needs additional information to conduct its review (this is referred to in HIOS as a "request for supplemental materials"). Lastly, when a rate review determination is made by either a State or CMS, issuers will receive an email notification of the determination. All issuer emails are sent to submitter and attester users.	2011		iles/rate_review_training.html
Rate Review Training: HIOS	**Q17:** What types of information will a State have access to in HIOS if CMS is conducting some or all of its reviews?	**A17:** States will have access to all Preliminary Justification submissions in HIOS, regardless of whether the review is being conducted by the State or CMS. However, the HIOS function that allows States to enter a rate review determination are only enabled if the review is being conducted by the State.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Issuer Reporting Requirements	**Q18:** What are the HIOS product IDs that were referenced in the webinar?	**A18:** A HIOS ID is assigned to each product that is registered in HIOS. The rate review module is populated with existing HIOS products and issuers may only submit rate review information for a product that is currently listed in HIOS. Issuers should contact CMS	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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		(ratereview@hhs.gov) if they identify a product that meets the rate review reporting requirements but is not currently listed in the HIOS rate review module.			
Rate Review Training: Issuer Reporting Requirements	**Q19:** What is the distinction between the terms "plan" and "product" for the purposes of the rate review reporting requirements?	**A19:** The rate review regulation defines the term "product" as a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State. A product may have numerous plans with different premium and cost sharing structures. The Preliminary Justification is reported at the product level; thus, all information in the Preliminary Justification must be aggregated to the product level. (As discussed in the next question, products may be aggregated under some conditions.) The definition of "product" in the rate review program tracks with the definition of "product" used in the HIOS Plan Finder. In practice, issuers will locate and report on products in HIOS using the product IDs that have already been entered into the system via the HIOS Plan Finder module.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Issuer Reporting Requirements	**Q20:** Healthcare.gov does not include information on closed block products. Do we have to submit rate	**A20:** Yes, the rate review reporting requirements apply to closed block products and issuers must submit information on closed block rate increases in HIOS. While no information on closed block products is	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	review information on these products in HIOS?	available on Healthcare.gov, HIOS does contain product IDs for closed block products.			
Rate Review Training: Issuer Reporting Requirements	**Q21:** Currently no information is collected in HIOS on products offered in the U.S. Territories. Do issuers have to report on these products?	**A21:** Yes, the rate review requirements do apply to products offered in the U.S. Territories. In order to accommodate reporting of these products, issuers will be required to submit information on Territory products during the August Plan Finder reporting window. CMS will provide additional guidance regarding the information that issuers must provide on these products. Please note that when CMS refers to the term "State" as it concerns rate review, it includes Territories unless otherwise specified.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Issuer Reporting Requirements	**Q22:** What is the definition of small group market in the rate review program?	**A22:** At this time, the rate review program follows existing State definitions for the small group market.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Issuer Reporting Requirements	**Q23:** To what type of products do the rate review reporting requirements apply?	**A23:** The rate review reporting requirements apply to individual and small group products offered by health insurance issuers. The requirements do not apply to grandfathered products as defined in 45 C.F.R. § 147.140, or to excepted benefits as described in Public Health Service Act section 2791(c). The rate review reporting requirements do not apply to Medicare and Medicaid products, such as Part C and D products, Medicaid managed care products, or Medicare supplemental products.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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Rate Review Training: Preliminary Justification	**Q24:** When will the Excel file for Part I of the Preliminary Justification be available?	**A24:** The Preliminary Justification is still pending Paperwork Reduction Act (PRA) approval. Currently the CMS CCIIO website has a link to the PDF version of Part I at http://cms.gov/cciio/resources/other/index.html#rir . The version posted was released on 5/27/11 for public comment. CMS will post the final Excel version of Part I as soon as the PRA approval process is complete.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Preliminary Justification	**Q25:** How should issuers address concerns or questions about specific data elements contained on the Preliminary Justification?	**A25:** Issuers should submit their questions or concerns about the Preliminary Justification to ratereview@hhs.gov. These questions will be addressed on the ongoing user group calls and responses will be included in updated versions of the FAQ.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Preliminary Justification	**Q26:** In the event that no rate increases are anticipated, is a filing still required?	**A26:** No. A HIOS Preliminary Justification submission is not required if there is not a rate increase, or if a rate increase is not subject to review.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Preliminary Justification	**Q27:** Section C of Part 1 of the Preliminary Justification includes the following items: 1. Projected net claims 2. Administrative costs 3. Underwritting gain/loss	**A27:** Contract reserves should be included in the "Projected net claims" category of the Preliminary Justification, Section C, Part 1. Furthermore, the more detailed rate filing must break out contract reserves and justify them (reason for holding, tabular basis, etc.).	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	4. Total rate For individual carriers that hold contract reserves, where should the contract reserves be included in the categories above?				
Rate Review Training: Preliminary Justification	**Q28:** How should issuers include contract reserves in the projected net claims when the claims are projected from Section A with no category for contract reserves?	**A28:** The contract reserves should be allocated over the Part A net claim costs in proportion to the level of the claims by provider before contract reserves are added.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Preliminary Justification	**Q29:** When will the 10% Threshold calculation training module be available?	**A29:** CMS posted the webinar training module on August 12th. The training was posted with the other issuer training modules currently posted on CMS' training webpage.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: State Requirements	**Q30:** When States provide links on their websites to the Preliminary Justification for a particular filing, should the link take the consumer to the posting for that particular filing, or to the main	**A30:** Under effective rate review program requirements, States must post on their websites, information on each proposed increase that is subject to review. CMS previously advised States that they could comply with this requirement by linking to each rate filing's corresponding consumer disclosure on HealthCare.gov (which contains Parts I and II of the Preliminary Justification in a consumer-friendly	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	Healthcare.gov webpage?	format). To make it easier for States to comply with this web-posting requirement, it is acceptable for a State to provide a hyperlink to the State's rate filing search result page on http://companyprofiles.healthcare.gov/ - Opens in a new window . We are aware that some States are linking to the main HealthCare.gov company profile search page instead of the State-specific search result page. It is not sufficient to link to the main search page; the link must go to the State's search result page that lists all rate filings (and corresponding consumer disclosures) for the State. In addition, States may continue to provide a hyperlink to the particular consumer disclosure on HealthCare.gov for each rate filing under review. To assist States in providing the consumer disclosure hyperlinks, we created a new report in HIOS with a listing of records posted on HealthCare.gov. The new report labeled "Rate Review Records on HealthCare.gov" has been added to the Announcements page for State HIOS users. This report provides the links to all rate review records that are posted for a respective State on Healthcare.gov (it is updated in real time as new records are posted to HealthCare.gov). The report is provided in XML format, so that States can use their reports to create automated processes for updating the			

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		rate review information on their websites. States should consult with their website development staff to get the maximum benefit from this feature. If you have about any questions about the web-posting requirement or the new HIOS enhancement, please email us at RateReview@hhs.gov.			
Rate Review Training: State Requirements	**Q31:** Will CMS provide a template for the description of the rate review findings that States must include with each rate review determination submitted in HIOS?	**A31:** This description will be posted with the filing record on Healthcare.gov and is primarily intended to provide consumers with information about the review process and determination. CMS did not provide a template as we do not want to prescribe how States explain their review findings to consumers. However, the State Rate Review Manual contains a set of guidelines that States may consult when they are preparing the explanation of their review.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q32:** Pooling of products: A company has in its small group line of business four products: A, B, C and D. The experience for the four products is pooled to get a rate increase for the pool. There is another process that sets the	**A32:** Since the rate increases are different on each of the four products, four different Preliminary Justifications are needed, one for each of the four products.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	benefit relativities between products. This means annual average rate increases for each product can be different from both other products and the pool. For example, one might see: -A pool increase of 12% -An annual product increases after a change in benefit relativity: Product A increases 14%, Product B increases 10%, Product C increases 11%, and Product D increases 13% Would this company be required to submit one Preliminary Justification at the 12% level or four Preliminary Justifications (one for each product)?				
Rate Review Training: Technical Questions Related to Filings	**Q33:** Some carriers have had historical experience that justifies assuming	**A33:** State law and State standards as to what is unreasonable or not unreasonable should continue to be applied in States that have effective rate	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	trend factors much greater than those for most of the other carriers, resulting in requested increases greater than 10%. The carrier is aware that its experience is unusual and is investigating, but does not yet have an explanation. Should the requested increase be considered reasonable?	review programs. In States where CMS is performing the review, the standard used to make an unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation. States with an effective rate review program should continue to apply their standard using all the facts of the case.			
Rate Review Training: Technical Questions Related to Filings	**Q34:** A carrier has consistently filed significant rate increases on a block of business over several years. As a result of this history, the healthy insured's have tended to terminate their coverage leaving the unhealthy insured's trapped in a "death spiral." The current large increase is seemingly justified based on recent historical loss ratios. Should the requested	**A34:** The answer is the same as the preceding question. State law and State standards as to what is unreasonable or not unreasonable should be applied in States that have effective rate review programs. In States where CMS is performing the review, the standard used to make an unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	increase be considered reasonable?				
Rate Review Training: Technical Questions Related to Filings	**Q35:** Does the 10% rate increase threshold that triggers review apply only to the weighted average increase or are minimum and maximum increases considered as well?	**A35:** The threshold test trigger uses the weighted average premium rate increase to determine if a given increase is subject to review. The maximum increase and minimum increase are not used in the threshold test.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q36:** The final regulation requires issuers to file a Preliminary Justification at the product level. Some States focus their review at the filing level. Thus, States may review multiple Preliminary Justifications per rate filing. How does CMS envision the State's review process to operate in this case?	**A36:** If a filing includes more than one product, a State with an effective review process should conduct the review of the filing in the manner in which it normally conducts such reviews. The regulation should not cause any State with an effective rate review program to change the manner in which it reviews rate filings. However, a separate result will have to be entered for each Preliminary Justification record that appears in the HIOS system. In the case where a filing contains several products that are pooled for one Preliminary Justification submission, the result of the review would be entered into the HIOS system just one time for the pooled record.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q37:** Would the determination for all Preliminary Justifications	**A37:** The determination for each product need not be identical.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	described in item 36 be identical?				
Rate Review Training: Technical Questions Related to Filings	**Q38:** Would there ever be a case in which different products within one rate filing received different determinations?	**A38:** Yes, it is conceivable that the same proposed rate increase would be unreasonable for one product in the filing and not unreasonable for another.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q39:** Does CMS have guidance in the event of the situation described in item 38?	**A39:** CMS does not have additional guidance at this time. States with effective rate review programs should follow their State law and State standards in making any determination as to whether a particular product increase is unreasonable or not.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q40:** There is a group health insurance carrier in a State which does not have an effective rate review process. The carrier's rates are effective 10/1/2011, but renewal notices will go out to members beginning on 8/1/2011. Does the Carrier have to file with CMS before "implementation" of the rates? Is implementation the	**A40:** Yes. For States with a filing requirement, filings submitted on or after September 1, 2011 are subject to the rate review regulation. For States where there is no filing requirement (i.e, no effective rate review program), increases with an effective date on or after September 1, 2011 are subject to the rate review regulation and must file all three parts of the Preliminary Justification with CMS. The implementation date is the effective date of the rate increase. The renewal letter has no bearing on the timing of the Preliminary Justification submission to CMS.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	date the renewal letters go out, or the effective date of the rate increase?				
Rate Review Training: Technical Questions Related to Filings	**Q41:** If a filing includes a requested rate increases of 7%, 12% and 14% for three different products, how many preliminary justifications would be required for this filing?	**A41:** The most granular level of submission for the Preliminary Justification is the product level. Two or more products can be submitted together in one "pooled" Preliminary Justification submission if the product's experience is combined or pooled for the purposes of rate making AND the products submitted together have the same increase. If the experience for two or more products was not combined or pooled for rate making purposes, a Preliminary Justification must be submitted for each product.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Technical Questions Related to Filings	**Q42:** For the same filing mentioned in item 41 above, rather than 3 different increases, the filer decided to request the same increase of 11% for all 3 products, and the increase was based on the combined experience of the products. In this case, would the filer be required to submit just one preliminary	**A42:** The filer may combine the three products into one Preliminary Justification, but is not required to do so.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html

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	justification?				
Rate Review Training: Technical Questions Related to Filings	**Q43:** For the same filing mentioned in item 41 above, the filer pooled the experience from all three products but decided to allocate different increases to each product. The total of all the increases was equivalent to the overall increase based on the combined experience. Would you consider the increases unreasonable?	**A43:** State law and State standards as to what is unreasonable or not unreasonable should continue to be applied in States that have effective rate review programs. In States where CMS is performing the review, the standard used to make an unreasonable determination is the three-pronged excessive, unjustified, and unfairly discriminatory standard, as articulated in the federal rate review regulation.	FAQ August 22, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/rate_review_training.html
Rate Review Training: Public Disclosure of Rate Review Information	**Q1:** What rate information will be displayed on HealthCare.gov for consumers?	**A1:** After a health insurance issuer (issuer) attests to a Preliminary Justification, CMS will post a standardized, consumer-friendly presentation of Parts I and II of the Preliminary Justification on HealthCare.gov. Consumers may find this information for their state by going to http://companyprofiles.healthcare.gov/ - Opens in a new window. Each consumer disclosure will be displayed on a separate webpage.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training:	**Q2:** Does the issuer	**A2:** CMS generates the consumer	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/T

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
(HHS/CCIIO; Labor; Treasury/IRS)

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Public Disclosure of Rate Review Information	prepare the consumer disclosure, or does the State or CMS generate it based on the Preliminary Justification Rate Summary Worksheet data submitted by issuers?	disclosure electronically. The consumer disclosure is a consumer-friendly standardized presentation on the Healthcare.gov website of the information submitted by issuers in Parts I and II of the Preliminary Justification. After issuers submit the Preliminary Justification to CMS, CMS' data collection system calculates the data elements that are used to populate the consumer disclosure. Each consumer disclosure will be posted in HTML format on HealthCare.gov (as opposed to document file such as a PDF). Issuers are not required to prepare a separate "consumer disclosure" document.	24, 2011		raining-Resources/rate_review_faq.html
Rate Review Training: Public Disclosure of Rate Review Information	**Q3:** What information will be displayed on HealthCare.gov if an issuer withdraws a rate increase after CMS or the State has made a review determination?	**A3:** The consumer disclosure information from Parts I and II of the Preliminary Justification that CMS posts on HealthCare.gov will remain posted for two years. When information is first posted on HealthCare.gov, the review status will be displayed as "review pending." Following the completion of the review, the review status will be updated on HealthCare.gov to reflect the final review determination (e.g., "not unreasonable"). If the record is subsequently withdrawn by the issuer after the review determination, the status will be updated on HealthCare.gov for a third time. The updated status will provide information	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		on the final determination (e.g., "not unreasonable") and will state that the issuer withdrew the increase prior to implementation.			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q4:** If contractors work for more than one State, do they have to submit a separate HIOS registration for each State that they work for?	**A4:** Yes, each State needs to independently request HIOS access for its contractor(s) in the State's registration request. Contractors will be assigned a separate login for each State they work for.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q5:** Is HIOS set up to identify whether a given product will be reviewed by States or CMS?	**A5:** Yes, HIOS will automatically identify whether a given product will be reviewed by the State or CMS during the issuer's Preliminary Justification upload process. Information on who is conducting the review is clearly displayed in HIOS	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q6:** What is the significance of the "review in progress" status in HIOS?	**A6:** For CMS reviews, CMS will assign this status to records within two days of issuer attestation. CMS intends to use this intermediate status to help us distinguish between new records that have just been submitted in the system and existing records that we have already looked at. For State reviews, the State HIOS users may use the "review in progress" status at their own discretion.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q7:** The training materials state that HIOS is pre-populated with Plan	**A7:** The Plan Finder consumer tool is available on the HealthCare.gov website (click on the tab labeled "Find Insurance Options"). Technical guidance	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	Finder "products" and that issuers will only be able to submit rate review information for products that are already registered on Plan Finder. Where can I find more information on Plan Finder?	regarding Plan Finder can be found at http://www.cms.gov/ccciio/programs/healthcare/index.html.			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q8:** If there are States where issuers have products that were not required on Plan Finder, when will issuers receive a HIOS issuer ID for those States/products?	**A8:** Issuers are required to report on all of the their individual and small group major medical products in Plan Finder and in general all of the products subject to the rate review reporting requirements should be captured in HIOS. Issuers recently received information about registering association plans that were not previously considered to be individual and small group market plans in Plan Finder.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q9:** Are issuers required to combine all rate changes within a product/State into one HIOS ID? For example, if there are individual major medical, conversion, and HIPAA plans in the same product and	**A9:** Rate increases are reported at the HIOS Plan Finder level. Issuers do not need to make any changes to their existing Plan Finder product designations in order to accommodate the rate review reporting requirements. In general, the issuer reported Plan Finder product IDs track to how issuers report on products at the State level. A given Plan Finder product may contain a mix of conversion, HIPPA,	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	State, are these required to be within one HIOS issuer ID for the purposes of the threshold test and Preliminary Justification?	and other plan types. Issuers do not have to make any changes to these products in Plan Finder. For the purposes of rate review reporting, issuers should consider the average increase assessed to enrollees across all of these product types that are grouped together in Plan Finder.			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q10:** Are issuers required to update their Plan Finder product and plan information to track with their rate filings?	**A10:** No, products should not be organized in Plan Finder to track with rate filings. Issuers are required to report on products in a manner that is consistent with their product reporting at the State level (e.g., State financial reporting). In some cases this may not align with how plans are grouped together in filings. For example, a product with conversion and non-conversion plans may be subject to two separate State filing requirements (a conversion plan filing and a non-conversion plan filing). In this case, the issuer would calculate the threshold rate increase test at the two points in time corresponding to each rate filing. In the calculation of the threshold test for the rate filing, the issuer would consider all enrollment in the product (enrollment in the plans with and without the rate increase). The cumulative effect of both rate increases would be taken into account during the threshold test for any second filing, provided that the second filing occurs within 12 months of the first (the issuers	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		would take the weighted average of the increases assessed across all plans).			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q11:** What should an issuer do if it is not currently reporting product information in Plan Finder?	**A11:** Organizations must have an existing HIOS Plan Finder issuer ID in order to register for the rate review data reporting system (this information is required as part of the registration request). This means that organizations must first register for access to the Plan Finder system and establish HIOS issuer and product IDs before they can register or use the rate review data reporting system. The Plan Finder website contains technical information on HIOS Plan Finder reporting requirements, including the Plan Finder Excel template, detailed technical instructions, and Q&As. This information may be found on the CCIIO website at http://www.cms.gov/cciio/resources/forms-reports-and-other-resources/index.html#content requirements for Healthcare.gov. The materials on this site should provide issuers with the information they need to register for Plan Finder and to report products in Plan Finder. CMS has dedicated issuer support services for additional guidance on Plan Finder reporting: •For policy questions regarding the HealthCare.gov Plan Finder, please email CCIIOPlanFinder@cms.hhs.gov. •For technical assistance regarding Plan	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		Finder data submissions, please contact the HIOS Help Desk at 1-877-343-6507 or insuranceoversight@hhs.gov.			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q12:** If issuers discover a product that is subject to review but is not listed in the HIOS Rate Review module, what is the process for getting that product added?	**A12:** In general, new products may only be registered in Plan Finder during a scheduled data refresh period (the next refresh period is scheduled to run from November 16 through November 23, 2011). HIOS rate review users should work through their organizations' designated HIOS Plan Finder data submitters to make changes to update the products displayed in HIOS. This may mean that there will be a short delay between when an issuer submits a rate filing to a State and when the corresponding Preliminary Justification is submitted in HIOS. While issuers are required by 45 C.F.R. § 154.220 to submit a Preliminary Justification to the State and CMS by the date the State requires the filing to be made. CMS appreciates that there may be isolated cases where issuers must add additional products into HIOS to accommodate the rate filing requirements. It is acceptable for the issuer to first submit a rate increase to the State (if the State requires filings) and follow up with CMS with a Preliminary Justification submission as soon as the Plan Finder product data has been added to HIOS (i.e., issuers do not have to delay submitting rate filings to States). In this situation, we recommend that issuers	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		submit an email to RateReview@hhs.gov explaining the discrepancy between the filing date and the Preliminary Justification submission date. As it is likely that organizations may assign two different sets of HIOS users for the Plan Finder and Rate Review modules, HIOS rate review users should contact and work through their organization's designated Plan Finder users to make any modifications to their existing list of products			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q13:** Plan Finder is mislabeling plans as products. How can we fix that problem?	**A13:** Your organization's designated Plan Finder user can resolve the issues involving products already entered in Plan Finder by notifying the Plan Finder help desk at insuranceoversight@hhs.gov. An organization does not need to wait until a Plan Finder refresh period (period during which new products can be added) to reclassify products as plans. The Plan Finder team in CMS can make these changes in the system for issuers.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q14:** The rate review reporting requirements do not apply to grandfathered plans. Do issuers have to make any changes to Plan Finder products that contain a mix of	**A14:** No. Issuers do not need to make any changes in the way these products are reported in Plan Finder. However, issuers should base the rate increase threshold test on the rate increases applied to only the non-grandfathered segment of product.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	grandfathered and non-grandfathered plans (i.e., should these products be split into a grandfathered only and non-grandfathered only product in HIOS)?				
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q15:** Do issuers have to report on any types of coverage that are currently not reported in Plan Finder, such as hospital only coverage or short term medical coverage?	**A15:** No. Issuers are required to report only on the products that are currently captured in the Plan Finder reporting requirements.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q16:** Do issuers have to report on low enrollment plans?	**A16:** Under certain circumstances, issuers do not have to report low enrollment plans in the HIOS Plan Finder module. However, the rate review reporting requirements apply to products, not plans. Issuers are required to report information on all products in Plan Finder, regardless of the total enrollment at the product level. The Plan Finder low enrollment exclusion policy applies to plans, not products. So while some individual plans might be missing from HIOS, there should not be any missing products due to the low enrollment exclusion rule.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		Specifically, as issuers are required to report rate increases at the product level (not the plan level), there is no need for issuers to amend their existing Plan Finder data with additional information on low enrollment plans that are currently not included in Plan Finder.			
Rate Review Training: Health Insurance Oversight System ("HIOS")/Plan Finder	**Q17:** How will association products be reported on in HIOS?	**A17:** The Rate Increase Disclosure and Review Final Rule was amended on September 6, 2011. As a result, effective November 1, 2011, the definitions of individual and small group markets that apply for rate review purposes now include coverage sold to individuals and small groups through associations, even if the State does not include association coverage in its definitions of individual and small group markets. Prior to the September 6, 2011 amendment, issuers were already required to report on any association product that was included in a State's definition of individual or small group products (45 C.F.R. § 154.102). In light of the amendment, issuers must now report on any individual and small group products sold through associations, even if a State otherwise excluded or excludes such coverage from its definitions of individual and small group markets. Because the original final rule deferred to State definitions of a large group and the regulation did not cover large group	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		plans, Plan Finder does not yet include association products that are considered to be large group under a State's definition. If such association products fall under the new amendment and are subject to the rate review regulation, the association product must be added to Plan Finder. Issuers will have to add these products during the refresh running from November 17 to 23, 2011 (the period during which new products can be added to Plan Finder).			
Rate Review Training: State Requirements	**Q18:** States with Effective Rate Review Programs are required by 45 C.F.R. § 154.301(b) to provide access to Parts I and II of the Preliminary Justification and can satisfy this requirement by linking from their websites to HealthCare.gov. What link to HealthCare.gov should a State use on its website to comply with this requirement, and when does the requirement take effect?	**A18:** CMS will be posting a standardized, consumer-friendly version of Parts I and II of the Preliminary Justification on HealthCare.gov. We refer to this as the "consumer disclosure." States may provide links on their website to the product-specific consumer disclosure located on CMS' HealthCare.gov website at http://companyprofiles.healthcare.gov/ - Opens in a new window . To make it easier for States to comply with this web-posting requirement, it is also acceptable for a State to provide a hyperlink to the State's rate filing search result page on http://companyprofiles.healthcare.gov/ - Opens in a new window . We are aware that some States are linking to the main HealthCare.gov company profile search page instead of the State-specific search result page. It is not sufficient to link to the main search page; the link must go	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		to the State's search result page that lists all rate filings (and corresponding consumer disclosures) for the State. In addition, States may continue to provide a hyperlink to the particular consumer disclosure on HealthCare.gov for each rate filing under review. To assist States in providing the consumer disclosure hyperlinks, we created a new report in HIOS with a listing of records posted on HealthCare.gov. The new report labeled "Rate Review Records on HealthCare.gov" has been added to the Announcements page for State HIOS users. This report provides the links to all rate review records that are posted for a respective State on Healthcare.gov (it is updated in real time as new records are posted to HealthCare.gov). The report is provided in XML format, so that States can use their reports to create automated processes for updating the rate review information on their websites. States should consult with their website development staff to get the maximum benefit from this feature. If you have about any questions about the web-posting requirement or the new HIOS enhancement, please email us at RateReview@hhs.gov.			
Rate Review Training: State Requirements	**Q19:** The State Rate Review Instructions Manual says that States should notify	**A19:** States may advise CMS of such filings by sending an email to RateReview@hhs.gov. If possible, please include the following information	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	CMS of instances where issuers fail to submit to CMS Preliminary Justifications for rate increases that are at or above the threshold. How should States communicate this information to CMS?	in your email: 1) the company; 2) the HIOS ID; 3) the product; and 4) a brief description of the rate increase and why it should have been submitted to CMS. We appreciate the States working with us in this regard.			
Rate Review Training: State Requirements	**Q20:** If CMS is performing the rate review, what information will the State have access to in HIOS?	**A20:** When CMS is doing the review, States will have access in HIOS to Parts I, II, and III of the Preliminary Justification. States will get an email from CMS when a Preliminary Justification has been submitted and attested to in HIOS by an issuer in their State. States will have immediate access to this information in HIOS, before the information is publicly available on CMS' website. States will also have access to CMS' final determination in HIOS, which will allow States to view it before the determination is publicly posted.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: State Requirements	**Q21:** Will CMS provide to the States its rate review process and how CMS is using the data from the Preliminary Justification to	**A21:** CMS will determine if a rate increase is unreasonable in accordance with 45 C.F.R. § 154.205, which states that CMS will determine that a rate increase is unreasonable if it is excessive, unjustified, or unfairly discriminatory. Additionally, the Issuer Rate Review Manual provides	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	determine if a rate increase is unreasonable?	significant detail on the information that will be assessed during CMS' review process. CMS and reviewing States are required to post a brief explanation of the reasons for their determinations.			
Rate Review Training: State Requirements	**Q22:** If a State is performing the review and the increase is modified, should the State enter the modified "Threshold Rate Increase" or the modified "Overall Rate Increase" in the "Modified Rate Change (%)" field?	**A22:** States must enter the modified threshold rate increase amount. In other words, the modified rate increase amount should be calculated using the threshold rate increase calculation so that the modified increase amount is comparable to the original increase.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Issuer Reporting Requirements	**Q23:** Are there any reporting requirements if the rate increase is below 10% based on the calculation as outlined in the Preliminary Justification form?	**A23:** Federal reporting is not required under the federal rate filing requirements only if the rate increase is less than the 10% threshold. Issuers must continue to comply with all State laws and filings requirements.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Issuer Reporting Requirements	**Q24:** Do health insurance issuers in a State with an Effective Rate Review Program have to register for HIOS and submit rate increase data to	**A24:** Yes. Pursuant to 45 C.F.R. § 154.215 et seq., issuers in effective rate review States must register for the rate review module in HIOS (and should take the rate review training webinars). Regardless of whether the State or CMS is doing the review, health insurance issuers are required to submit in HIOS	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	CMS?	the Preliminary Justification, Parts I, II, and III, as applicable, to CMS. Please note that issuers must separately register with CMS for the Rate Review HIOS module even if they are already registered in HIOS for other programs.			
Rate Review Training: Issuer Reporting Requirements	**Q25:** Do self-funded plans have to comply with the rate filing requirements under section 2794 of the Public Health Service Act or 45 C.F.R. Part 154?	**A25:** No. The federal rate filing requirements do not apply to self-funded plan rates.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Issuer Reporting Requirements	**Q26:** When do issuers need to submit the Preliminary Justification in HIOS? Does the submission have to precede enrollee notification?	**A26:** The submission deadlines for the Preliminary Justification are based on State rate filing requirements. If a State has a filing requirement, issuers must submit the Preliminary Justification in HIOS by the State's rate filing date (45 C.F.R. § 154.220(a)). In States without filing requirements, issuers must submit the Preliminary Justification prior to the implementation date of the rate increase (45 C.F.R. § 154.220(b)). The enrollee notification date has no bearing on the submission deadline for the Preliminary Justification.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q27:** Under section (1) of the Preliminary Justification Part III Reporting Requirements, what	**A27:** These are two items from a list of items to be reported in Part III. The purpose of some of the items on this list, including these two, is to distinguish between an issuer's multiple filings, and to identify the business that is the	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	do the terms "Form Number" and "Product Number" mean?	subject of the filing. Many States require a listing of the form numbers covered in a filing. Typically this is an alpha/numeric code that identifies an insurance benefit. A product number is used less frequently, and varies with the regulatory entity requesting it. If a State requires issuers to use a product number, then the issuer could furnish it in the Part III filing. For purposes of federal rate increase filing requirements, if a State does not require an issuer to use form numbers and/or product numbers, and the issuer does not have any comparable internal identifier to distinguish one filing from another, the issuer does not have to furnish these items to CMS as part of its rate filing.			
Rate Review Training: Preliminary Justification	**Q28:** If a filing involves both grandfathered and non-grandfathered plans, should grandfathered plan data be included in the data for the Preliminary Justification?	**A28:** The rate review reporting requirements do not apply to grandfathered plans. However, issuers should fill out Part I of the Preliminary Justification using the same underlying data that was used to develop the rate increase (i.e., the experience of a grandfathered plan should be included in the Preliminary Justification if these data were used to develop the rate increase). If CMS is reviewing the filing, only the non-grandfathered plan data will be considered in the review.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q29:** Can you please clarify how the	**A29:** The worksheet uses the inputted data on claims, administrative, and	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	"overall rate increase" in Section C can be different from the "threshold rate increase" in Section F, regardless of whether or not the issuer implements multiple periodic increases?	underwriting information for the 12-month periods immediately before and after the rate increase effective date to calculate an overall rate increase in Section C. This rate increase may not always match the rate increase derived from the subject to review threshold test. The two rate increase values may be the same when issuers are not implementing multiple or phased-in rate increases, such as a one-time 11% increase that is assessed to all beneficiaries on the rate increase effective date. However, the calculated rate increase amount in Section C will not match the threshold rate increase in cases where an issuer implements multiple periodic increases. For example, the threshold increase will not match the overall rate increase calculation in Section C if the issuer is proposing a rate increase implemented quarterly upon policy renewal. The rate increase exercise on the worksheet requires issuers to show how their anticipated costs will change between the current year (status quo) and under the rate increase. Issuers should always complete Sections A, B, and C with historical and projected data that represents their actual experience and trend assumptions. Issuers should not modify their data in order to make the overall rate increase calculation in			

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		Section C match the threshold rate increase. The information contained in Sections A, B, and C of the Preliminary Justification are intended to give consumers a standardized presentation of changes in issuers' claims, administrative and underwriting gain/loss revenue needs. These data are not intended to directly tie to the threshold rate increase.			
Rate Review Training: Preliminary Justification	**Q30:** Is it acceptable to use more than 12 months of data in Section A? If yes, then would the trend be applied for a longer period (from the mid-point of the base period to the mid-point of the projection period)?	**A30:** It is acceptable for the experience in Section A to cover more than 12 months. And if that is the case, then the trending would be from the middle of the experience period to the middle of the projection period.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q31:** Please explain the "prior estimate of current rate" in Section C? What if we do not have this data from a prior filing?	**A31:** Please use the prior estimate for the premium in force before the effective date of the proposed rate change, and include the estimate of the claims and other components based on the assumptions used then. Regarding the second question, it would be unusual for the information to be unavailable. If this information cannot be obtained, or if there is some other barrier that cannot be resolved, the issuer should contact CMS with specific	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		details.			
Rate Review Training: Preliminary Justification	**Q32:** If the requested increase in the rate filing is different than the rate increase in Part C of the Rate Summary Worksheet, which increase will the consumer disclosure explain?	**A32:** The threshold rate increase value will be displayed on the consumer disclosure (the rate increase value from Part C is not displayed).	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q33:** Similarly, should the written explanation of the increase (Part II) discuss the increase actually requested, or the rate increase in Part C of the Rate Summary Worksheet?	**A33:** The written explanation should discuss the increase actually assessed to individuals. Note that the instructions for Part II direct issuers to describe the range and scope of the increase. To this end, issuers should describe the increase actually assessed to the different cohorts affected by the increase.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q34:** In the case where there are quarterly rates filed, for a year in advance, is it correct that we must weight those together to determine if the overall increase meets the threshold? If so, then what goes into C (and B)?	**A34:** For quarterly rates filed a year in advance, the issuer should independently evaluate the impact of each quarterly impact. Specifically, for each quarter, the issuer should calculate the overall rate increase, based on the average rate under each quarterly increase compared to the average rate twelve months before the quarterly increase. The filing would be subject to review if any of these calculations resulted in an increase at or above 10% (the issuer should report the largest of	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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		these increases). In Section F of the Preliminary Justification, the issuer should report the rate increase that is calculated using our threshold rate increase formula. The issuer should complete sections B and C of the Preliminary Justification based on their estimated costs for the 12 months immediately before and after the rate increase effective date (this would be the date of the first quarterly increase under the example provided in this question). The resultant overall rate increase calculated in Section F may not be the same as the threshold rate increase. For Sections A-C of the Part I of the Preliminary Justification, issuers should provide data on their claims, administrative, and underwriting estimates for the 12-month periods immediately before and after the rate increase effective date. An overall rate increase that is calculated in Section C based on these data may not always match the rate increase derived from the subject to review threshold test (this value is reported separately on the form in Section F). The two rate increase values may be the same when issuers are not implementing multiple or phased in rate increases, such as for example a one-time 11% increase that is assessed to all beneficiaries on the rate increase			

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		effective date. However, the calculated rate increase amount in Section C will not match the threshold rate increase in cases where an issuer implements multiple periodic increases. For example, the threshold increase will not match the overall rate increase calculation in Section C if the issuer is proposing a rate increase implemented quarterly upon policy renewal.			
Rate Review Training: Preliminary Justification	**Q35:** Assume an issuer has to submit a Preliminary Justification for four products. The pool increase was calculated by pooling all four products together. The final difference between the annual product increases occurs due to things like leverage and other impacts on benefits. When the issuer fills out Part 1, should it use the experience of the pool, or just the experience specific to the particular product?	**A35:** The answer to this question depends on the exact base experience that was used in the pricing. If the products were priced from base period data that was aggregated to form a single pool, then that pool experience should be used to complete Part 1. If the different products were priced based on each product's separate experience, then the experience of each separate product should be used to fill out Part 1 for that particular product and four separate Part 1 forms – one for each product – should be submitted.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q36:** The rate review regulation defines the	**A36:** No. If there are two separate legal entities, there must be two separate	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	term "product" as a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State. It also states that two or more products can be submitted together in one "pooled" Preliminary Justification submission if the product's experience is combined or pooled for purposes of rate making and the products submitted together have the same increase. Assume that (1) an issuer operates under more than one legal entity in a State: HMO Company and Insurance Company; (2) the rating and pricing methodologies for the products under	Preliminary Justifications.			

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	both companies are the same; (3) the experience of such products under both companies are pooled for purposes of rate making and the rate increase is the same. May the issuer submit one Preliminary Justification to encompass both legal entities?				
Rate Review Training: Preliminary Justification	**Q37a:** Assume the following scenario: (1) an issuer operates under the same legal entity in two States; (2) the rating and pricing methodologies for the products in both States are the same; (3) the experience of such products under both companies are pooled for purposes of rate making and the rate increase is the same. We assume the issuer would still fill out two Preliminary Justification forms,	**A37a:** Two Preliminary Justifications are required, one for each State. In each case, Section F should be populated with the data for the State in which the rate is to be implemented. However, note that regarding the experience, if a filing is made for a rate increase that used common experience across several States, each of the different Preliminary Justifications may have some identical data for that common experience base.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	one for each State as Section E may vary between the two States. A) Does the issuer put only the members in State A in Section F of the form or does the issuer put in the members of State A and State B in Section F?				
Rate Review Training: Preliminary Justification	**Q37b:** If a filing requested rate increases of 7%, 12% and 14% for three different products, how many Preliminary Justifications would be required for this filing?	**A37b:** The product with the 7% increase does not trigger the threshold so it does not require a Preliminary Justification. The other products would each require a Preliminary Justification unless they meet the pooling requirements, in which case the issuer can submit them together in a single Preliminary Justification. Since the two products are treated disparately (different increases are applied), they must be submitted in separate Preliminary Justifications	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Preliminary Justification	**Q38:** For the same filing mentioned above with rate increases of 7%, 12% and 14% for three different products, if each increase was derived separately	**A38:** Yes, in order to be reported on a pooled basis (in one Preliminary Justification), their experience for rate development purposes must have been combined or pooled, but they also must have the same increase (i.e., they cannot have been treated disparately).	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	based on the product's own experience, would the issuer be required to submit two Preliminary Justifications for the filing, one for the 12% increase and one for the 14% increase?				
Rate Review Training: Preliminary Justification	**Q39:** For the same filing mentioned above with rate increases of 7%, 12% and 14% for three different products, the filer combined the experience from all three products but for some reason he decided to allocate different increases (7%, 12%, & 14%) to each of the products. In this case, is the issuer required to submit only 2 Preliminary Justifications since one of the increases is below the 10% threshold?	**A39:** Yes. The three products cannot be pooled for Preliminary Justification reporting since they are treated disparately. The product with the 7% increase does not trigger the threshold and is not subject to review; thus no Preliminary Justification must be submitted for it. The other two products each require its own Preliminary Justification data set submission.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training:	**Q40:** The regulation,	**A40:** No. Once a calendar year has	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/T

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Preliminary Justification	in § 154.20(d), states, "If a rate increase that does not otherwise meet or exceed the threshold under paragraph (c) of this section meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review . . . ." If a rate increase is being proposed for January 1, 2012 and the last increase for that product was effective January 1, 2011, is the earlier increase considered to have occurred during the 12-month period immediately preceding the increase?	passed, the 12-month period has expired.	24, 2011		raining-Resources/rate_review_faq.html

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Rate Review Training: Technical Questions Related to Filings	**Q41:** Do the instructions for meeting the subject to review threshold include any language that addresses the 10% limit as an "annual" limit? If not, is there anything that indicates previous filings for the year should be included to pass the 10% threshold?	**A41:** Rate increases for the 12-month period preceding the rate increase effective date must be aggregated to determine whether the specified threshold is met or exceeded.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Technical Questions Related to Filings	**Q42:** Please clarify the following example as to whether it is an increase over the 10% threshold. This example is about a State-mandated Open Enrollment plan in the individual market. The State mandates that in 2012 rates have a limit of 1.5 times the lowest comparable plan new business rate. In 2011 the limit was 2.0 times the lowest comparable plan new	**A42:** If the example cited is the only business in this filing, and if the maximum allowable Open Enrollment limits are being used, then the 2011 rate of $2,000 is actually being reduced to a 2012 rate of $1,710, so the 10% increase threshold has not been breached. In a setting such as this, the fact that trend alone exceeds 10% is not dispositive regarding the breaching of the threshold. It is the final rate that matters. The average rate increase over the entire filing will be reviewed. For example, suppose that an issuer was employing a 1.5 cap in 2011, despite the ability to cap at 2.0. Presumably if the 1.5 cap is retained in 2012, and 14% trend applies without further modifications by other elements, then the threshold would be breached because, as we understand the assumption, all rates would rise by 14%	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	business rate. Medical trend caused an increase in the lowest comparable plan new business rate of 14% for all ages. Below are simple numbers for illustration of just one age band. Note the 14% increase is applicable to all age bands. For example, for one age band the 2011 lowest comparable plan rate was $1,000. The 2.0 times limit allowed an Open Enrollment plan rate of $2,000 for this age band. Trend caused the increase in the lowest comparable plan rate to 1.14 times $1,000 or $1140, for 2012. The 2012 year's 1.5 times limit allowed an Open Enrollment plan rate of $1,710. Has the threshold been breached for this example?	over a one year period.			
Rate Review Training:	**Q43:** How should	**A43:** For any increase, the rate of	FAQ October	CCIIO	http://www.cms.gov/CCIIO/Resources/T

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Technical Questions Related to Filings	the cumulative "threshold rate increase" be calculated? In the examples provided, it appears the multiple rate changes over a 12-month period are just being summed. However, the subsequent rate changes would be applied on top of the previous rate changes, creating a slightly higher 12-month cumulative. For example, if a company files quarterly rate changes of 3%, the second quarter rate increase would be a 3% increase on the rates that had already undergone a 3% increase 3 months prior. If rates started at $100, the increasing rates would be as follows: $103, $106.09, $109.27, $112.55; resulting in a 12.55% increase, rather than	change should be determined by the actual increase in the premium rate. If the method used for each increase is multiplicative rather than additive, then indeed the compounding would result in the $100 premium reaching $112.55, as is the case in the example presented, and the threshold rate increase used in the test would be 12.55%, which is the difference of the $112.55 and the $100 (or $12.55), divided by the $100. Generally, to evaluate any particular increase, one has to include any impacts to premium from other increases that have occurred within a year of elapsed time measured from the effective date of the rate increase being evaluated. Thus, a single cliff increase (with no other increase within a year) is evaluated on its own. Regular quarterly increases would require one to include the impact of the previous three quarters. With the proposed increase being evaluated in this example, the compound increase effect is 12.55%. If the premium instead rose by an even $3 every quarter (from $100, to $103, $106, and $112 respectively the additive model) then the threshold rate increase would be 12% not 12.55%.	24, 2011		raining-Resources/rate_review_faq.html

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	a 12% increase. Which method of calculation should be used?				
Rate Review Training: Technical Questions Related to Filings	**Q44:** How do issuers handle the situation in those States for which they file an annual rate increase as of a given date and a maximum annual trend, which may be applied to the rates for subsequent effective dates? For example, consider the illustrative case where an issuer files an annual rate increase effective January 1 of 9.5% and a maximum annual trend of 12% (which implies a maximum increase in the rate of approximately 0.949% per month).	**A44:** The threshold testing should be based on the maximum increases that the issuer could apply. This is true both at the date of the filing that first addressed the maximum possible increase, and at the date of any subsequent filing covering a period for which part of the initially requested and approved maximum trend can still be implemented.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Technical Questions Related to Filings	**Q45:** How and when are benefit changes considered for the threshold test? In particular, are distinctions made	**A45:** All benefit changes, including those legally required and those the issuer chooses to make are included in the threshold test. Benefit changes that will only impact newly insured individuals are not included in the	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	between: a. legally required benefit changes; b. benefit changes that the issuer is choosing to make that will affect all policyholders; c. benefit changes that will only impact new issues; and d. optional benefit changes that the policyholder may elect (or reject)	threshold test. Optional benefit changes that the policyholder may elect (or reject) are changes in premium, not rates, and are not included in the threshold test.			
Rate Review Training: Technical Questions Related to Filings	**Q46a:** Consider the below scenario: In one filing an issuer is proposing the following rate increases: <u>Quarter 01/01/2012</u> Quarterly increase: 3.00% Annual rate increase: 0.08 <u>Quarter 04/01/2012</u> QI: 3.00% ARI: 0.11 <u>Quarter 07/01/2012</u> QI: 3.00% ARI: 0.09	**A46a:** Slide 12 of the Subject to Review Threshold Test training module states: "If a filing has periodic increases with multiple effective dates for its component increases, the greatest threshold rate increase for the filings should be used for the threshold rate increase." In this example, we have a 3% increase that is implemented quarterly. This is a periodic increase that constitutes a 13% threshold rate increase. The issuer need not submit two Preliminary Justification data sets; it only needs to submit one for the entire filing.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	Quarter 10/01/2012 QI: 3.00% ARI: 0.13 a. Given that two of the annual increases are greater than the 10% threshold, is the issuer required to submit two Preliminary Justifications for this filing?				
Rate Review Training: Technical Questions Related to Filings	**Q46b:** In general, in a filing that has periodic increases with multiple effective dates, is the issuer required to justify any annual rate increase above the 10% threshold within a Preliminary Justification?	**A46b:** Yes. In this example, we have a 3% increase implemented quarterly. This is a periodic increase that constitutes a 13% threshold rate increase. The issuer must justify any increase that is part of a Preliminary Justification that triggers the threshold.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Technical Questions Related to Filings	**Q46c:** The answer given for (a) above was that the issuer is only required to submit one Preliminary Justification (triggered by the 13% annual rate	**A46c:** Yes. When justifying a rate filing with multiple increases that trigger the threshold, the issuer must justify each rate increase. The same holds true if the rate increases were filed separately.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	increase). Should the 11% annual increase, effective 4/1/2012, also be justified/supported in the Preliminary Justification?				
Rate Review Training: Technical Questions Related to Filings	**Q47:** Below is an example of a rate increase request filing for either individual or small group policies renewing in 2012: a.1st quarter 2012 renewing business rate increase request is 10.5% b.2nd quarter 2012 renewing business rate increase request is 10.1% c.3rd quarter 2012 renewing business rate increase request is 9.7% d.4th quarter 2012 renewing business rate increase request is 9.2% The weighted average aggregate rate increase request is 9.8% for 2012. In	**A47:** No. This does not trigger the subject to review threshold. The threshold is based on a weighted average, and in this example, it does not exceed 10%.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	this example, would the subject to review threshold test be met or not?				
Rate Review Training: Technical Questions Related to Filings	**Q48:** Please clarify the treatment of changes in demographic, geographic and benefit factors (not changes in the actual demographics or elections). Should these changes be included in the calculation of the threshold rate increase (e.g., if benefit factors increase to adjust for deductible leveraging)? Should these changes be included in the calculation of the minimum and maximum rate increases (e.g., if a change in age factor increases rates an additional 5% for a given cohort, would that factor into the calculation of a maximum rate	**A48:** First, when discussing changes in factors, and not changes in individuals or cohorts of individuals that arise solely due to the application of the factors, and not discussing changes to those factors, the impact of changes to the underlying rate factors for demographic, geographic, and electoral factors are changes in the rate structure and would be included in the threshold rate increase test. Such changes would indeed also be included in the minimum and maximum rate increases as well. Second, when discussing factors that are not being changed, but cause premium changes due to individuals aging (under an issue age rated product), moving across geographic rating areas, or making elective changes in benefits, the changes in premiums are not considered to be changes in the rate structure and do not impact either the threshold rate increase test or the minimum and maximum rate increases.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	increase)?				
Rate Review Training: Technical Questions Related to Filings	**Q49:** On the Rate Summary Worksheet (Part I of Preliminary Justification), should the minimum and maximum percent increases align with the effective date of the threshold rate increase and the effective date of the overall rate increase, or should they be based on increases that are effective at any point during the approval period (assuming rolling increases are pre-approved)? Using Example 3A from the training, if the issuer filed an 8% increase on January 1 and an additional 4% increase on July 1 and increases were consistent across all plans and policyholders for each given effective date, would the minimum increase be 8% and would the	**A49:** In this example, it appears that all policyholders will get a 12% increase in the aggregate across the board so the minimum, maximum and average increases are the same. In cases where they differ, information for Part I of the Preliminary Justification should be entered using the effective date of the rate increase.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	maximum increase be 12%? If not, what would they be?				
Rate Review Training: Technical Questions Related to Filings	**Q50**: Please clarify whether the minimum and maximum increases in the Part I Preliminary Justification should be based on hypothetical or actual enrollees. In other words, should the maximum increase be calculated as the maximum increase across the current population, or the highest possible increase, even if it doesn't apply to any actual enrollees?	**A50:** The minimum and maximum rate increase should be based upon actual enrollees, except in the case where there is a rate increase (not an initial rate filing) and there are no enrollees, then the highest possible should be used.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Technical Questions Related to Filings	**Q51**: For the cumulative threshold test, are increases effective in the 12 months prior to September 1, 2011 considered for filings effective September 1, 2011 and after? For example, a filing was made November	**A51:** Yes. The 9% increase should be considered when calculating the threshold test.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	1, 2011, effective January 1, 2012, for 9%, and there is a prior approved increase that was filed in June 2011 and effective August 1, 2011 for 9%. Should the cumulative effect of both 9% increases be considered for the threshold test?				
Rate Review Training: Technical Questions Related to Filings	**Q52:** If changes made in the underwriting manual or methodology are implemented, would the effect of these changes be included in the threshold test?	**A52:** Any impact or changes in the underlying rate structure should be included in the threshold rate increase test.	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html
Rate Review Training: Technical Questions Related to Filings	**Q53:** In the case where rates are filed for a given time period, for example, First Quarter, 2012, and proposed trend factors for the rest of the year are filed, yet issuers have the ability to reevaluate the rates and file new rates each quarter, is the weighting	**A53:** If the September increase that brought the initial increase of 9.7% was effective within 12 months of the earlier increase, the effects of the two increases would be combined for the purpose of the threshold test for the September increase. If the two increases were filed separately, the earlier increase of 9.7% would not trigger the threshold or be subject to review, but the later incremental increase that brought the aggregate effect within one year over the threshold value would. If filed	FAQ October 24, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Training-Resources/rate_review_faq.html

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	necessary to determine the threshold? Or, would the increase subject to the threshold be based purely on the annual increase effective with January 1, 2012? For example, if January 2012 proposed rates correspond to an annual increase of 9.7%, yet application of the proposed trend factors would lead to an increase over 10% in September 2012, would an issuer need to consider the September increase in determining the threshold? Or would the issuer not need to file a Preliminary Justification with the First Quarter filing and instead need to file one with the Third Quarter filing if rates needed were producing an increase over 10%?	together, the compound increase filing would become subject to review. If any incremental increase in a filing made within a year of an earlier increase(s) triggers the threshold, the entire filing becomes subject to review. The effects of increase to rates from base increases as well as trend increases are both included in the threshold rate increase test.			
Grants to States to	**Q1:** What are the	**A1:** The Centers for Medicare &	FAQ May 8,	CCIIO	http://www.cms.gov/CCIIO/Resources/F

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Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	goals of this funding opportunity?	Medicaid Services (CMS) has released the third cycle of Rate Review Grant funding. This Funding Opportunity Announcement (FOA) is entitled "Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing", Cycle III of the Rate Review Grant Program. The Rate Review Grant program helps states to establish and enhance effective Rate Review programs as well as to enhance or establish data centers that increase health pricing transparency. The Cycle III Funding Opportunity Announcement (FOA) builds upon the successes that states have experienced in expanding their rate review programs, and in enhancing data centers' efforts to increase health pricing transparency.	2013		act-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q2:** What is a data center, and how do they increase pricing transparency?	**A2:** Data centers empower consumers and employers by increasing transparency in the health care system. Specifically, these centers collect, analyze, and publish health pricing and medical claims reimbursement data. Their publications help the public to better understand the comparative price of procedures in a given region or for a specific issuer or service setting. A good example is New Hampshire's HealthCost website (http://www.nhhealthcost.org/). Businesses and consumers can use this	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html

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		data to drive decision-making and reward cost-effective provision of care. In addition, health care providers can use health pricing data to better understand what drives health care quality and costs.			
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q3:** Who is eligible to apply for this funding opportunity?	**A3:** The FOA is open to all 50 states, the District of Columbia and the five U.S. territories to develop or enhance their respective rate review programs and/or establish data centers. Only one application per state is permitted, except in a state in which there are two regulating entities, each with a primary responsibility over the regulation of a portion of the private health insurance market. Data centers must be academic institutions or other non-profit organizations, and states may partner with existing data centers or establish new ones. Data centers can be located in the applicant state or in another state. The FOA contains additional detailed criteria related to eligibility. For a detailed description of eligibility, please see Section III, entitled Eligibility Information, in the grant solicitation. The grant solicitation can be found at www.grants.gov, Catalog of Federal Domestic Assistance (CFDA) 93.511.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html
Grants to States to Support Health Insurance Rate Review and Increase	**Q4:** When is the application due?	**A4:** The completed application is due August 1, 2013. In addition, applicants are required to submit a letter of intent	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html

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Transparency in Health Care Pricing		by June 17, 2013.			
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q5:** How can my agency apply for this funding opportunity?	**A5:** You can find the grant solicitation at www.grants.gov, Catalog of Federal Domestic Assistance (CFDA) 93.511.	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q6:** How much funding is available through this funding opportunity?	**A6:** A total of approximately $87 million is available for the Cycle III grants	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q7:** How have grantees used previous Cycle I and II funding? How does rate review save money for consumers?	**A7:** Grant recipients have used Cycle I and Cycle II Rate Review Grant funding in a number of ways, including seeking authority to review health insurance rate increases, expanding the scope of rate review, improving the rate review process, making information on health insurance rates publicly available through transparency initiatives, developing and upgrading technology, and by analyzing medical claims reimbursement data. Preliminary results indicate that effective rate review is helping states to slow down health insurance premium growth. As part of the Rate Review Grant Program, HHS collects data from states about all rate increases. Based on 2011 premium data, rate review helped to lower premiums in the individual and small group markets by an estimated $1	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html

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		billion compared to the amount initially requested.1 A recent research brief by the Assistant Secretary of Planning and Evaluation provided further evidence that rate review is restraining premium increases. The research brief found that, "the proportion of rate filings in which the requested increase was 10 percent or more declined from 75 percent in 2010 to 34 percent in 2012, consistent with the increased scrutiny that such requests now receive. Available data for 2013 suggest that this pattern of slower premium growth has been maintained so far in 2013, with only 14 percent of requested rates at 10 percent or more. In addition, the average premium increase in 2012 was 30 percent below that in 2010."2			
Grants to States to Support Health Insurance Rate Review and Increase Transparency in Health Care Pricing	**Q8:** What is new in this funding announcement regarding data centers? How does this funding opportunity relate to the hospital price transparency data recently published by the Department of Health and Human Services?	**A8:** This funding opportunity provides greater flexibility to and funding for data center activities. By increasing support for data centers, this funding opportunity will increase transparency throughout the medical system, including hospitals and other service settings. In addition to increased funding, data centers will benefit from the hospital charge data recently released by the Department of Health and Human Services. The new hospital charge data will supplement existing pricing data and help data centers to provide regional	FAQ May 8, 2013	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rr-foa-faq-5-8-2013.html

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		and national comparisons.			
Improving Health Insurance Protections for Students: Status of Student Health Insurance Coverage with Policy Years Starting Prior to January 1, 2012	**Q1:** On February 11, 2011, the Department of Health and Human Services (HHS) published a Notice of Proposed Rulemaking in the Federal Register relating to Student Health Insurance Coverage. The proposed regulation clarifies the circumstances under which health insurance sold to students enrolled in colleges and universities is considered a type of individual health insurance coverage. It also provides that certain Public Health Service (PHS) Act requirements would be inapplicable to such coverage. The proposed policy set forth in the proposed rule would be applicable to policy years beginning on	**A1:** The proposed regulation clarifies the circumstances under which health insurance sold to students is considered individual health insurance coverage, as opposed to short-term limited duration insurance under 45 C.F.R. § 144.103. Insurance coverage that meets the definition of short-term limited duration insurance under 45 C.F.R. § 144.103 is not subject to PHS Act requirements. With respect to student policies that are individual health insurance coverage, HHS will not consider PHS Act requirements to apply to such coverage for policy years that begin before the first policy year to which the final regulation will be applicable. In addition, issuers that had a reasonable belief that the insurance coverage that they were providing to colleges and universities met the definition of short-term limited duration insurance will not, for purposes of federal law, be considered to be out of compliance pending the start of the first policy year to which the final regulation will be applicable. Starting with the first policy year to which the final regulation will be applicable, any student health insurance coverage (that is, any insurance sold to students that does not meet the definition of short-term limited duration insurance set forth in 45 C.F.R. §144.103) will be subject to all	FAQ March 9, 2011	CCIIO	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/student_healthinsurance_faqs.html

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	or after January 1, 2012. What is the status of student health insurance coverage with policy years starting prior to January 1, 2012?	requirements that will apply to student health insurance coverage under the final regulation. States currently enforce the individual market requirements of title XXVII of the PHS Act. HHS wishes to avoid disruption in the student health insurance market during the period before the applicability of the final rule. Therefore, HHS is also clarifying that, during this period, if a State is otherwise substantially enforcing the individual market requirements but the State does not enforce those requirements with respect to student health insurance coverage (as it would be defined by the proposed rule), the State is nevertheless considered to be substantially enforcing the individual market requirements. The federal enforcement policy described above does not preclude States from imposing State law requirements on student health insurance coverage for policy years beginning before the final regulation's effective date. In other words, States can continue to enforce relevant provisions relating to student health insurance coverage under State law and are not required to roll back any State law protections already applicable to student health insurance coverage			
Enrollment of Children Under 19 Under the New	**Q1:** Will children in child-only individual	**A1:** Child-only insurance plans that existed on or prior to March 23, 2010,	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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Policy That Prohibits Pre-Existing Condition Exclusions	market health plans today be affected by the new access to these plans for children with pre-existing conditions?	and that do not significantly change their benefits, cost sharing, and other features, will be "grandfathered" or exempt from these regulations. As such, children enrolled in grandfathered child-only plans today are unlikely to be affected by the new policies.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q2:** Do these interim final rules require issuers in the individual health insurance market to offer children under 19 non-grandfathered family and individual coverage at all times during the year?	**A2:** No. To address concerns over adverse selection, issuers in the individual market may restrict enrollment of children under 19, whether in family or individual coverage, to specific open enrollment periods if allowed under State law. This is not precluded by the new regulations. For example, an insurance company could set the start of its policy year for January 1 and allow an annual open enrollment period from December 1 to December 31 each year. A different company could allow quarterly open enrollment periods. Both situations assume that there are no State laws that set the timing and duration of open enrollment periods.	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q3:** How often must an issuer in the individual market provide an open enrollment period for children under 19?	**A3:** Unless State laws provide such guidance, issuers in the individual market may determine the number and length of open enrollment periods for children under 19 (as well as those for families and adults). The Administration, in partnership with States, will monitor the implementation	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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		of the pre-existing condition exclusion policy for children and issue further guidance on open enrollment periods if it appears that their use is limiting the access intended under the law.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q4:** How do these rules affect existing enrollment requirements in States that already require guaranteed issue of coverage for children under 19 in the individual market?	**A4:** If a State requires continuous open enrollment or requires issuers to maintain an open enrollment period of a particular length or open enrollment periods of a particular frequency, then the State requirement will apply. The State law is not preempted by any current federal requirements.	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q5:** "Premium assistance" programs allow States to provide payments to help people eligible for Medicaid and Children's Health Insurance Programs (CHIP) enroll in private coverage. Won't the policy to ban pre-existing condition exclusions in new plans for children lead cash-strapped States to steer high-cost children into individual market	**A5:** Federal law prohibits Medicaid and CHIP from denying children coverage based on their health status. Moreover, it limits the extent to which these programs can provide payment to support coverage in individual market policies. "Premium assistance" programs in CHIP allow States to provide payment to private policies to cover children if doing so both protects children and is cost effective to the Federal and State governments. Premium assistance is not designed as a strategy to transfer vulnerable children to individual market coverage. The Administration will enforce its current policies on premium assistance and consider new ones if evidence emerges that children with pre-existing	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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	policies for children as a way to limit their own liability?	conditions are being diverted inappropriately from Medicaid or CHIP to private insurance plans that newly offer guaranteed issue to children regardless of their health status. HHS will not enforce these rules against issuers of stand-alone retiree-only plans in the private health insurance market.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q6:** Some issuers have expressed concerns about adverse selection from newly offering child-only health insurance on a guarantee issue basis, and have asked for clarifications of what they could do, consistent with the current regulations, to mitigate this concern?	**A6:** A number of actions have been suggested by insurance commissioners and insurers to address adverse selection in child-only policies. The following actions are not precluded by existing regulations: •Adjusting rates for health status only as permitted by State law (note: the Affordable Care Act prohibits health status rating for all new insurance plans starting in 2014); •Permitting child-only rates to be different from rates for dependent children, consistent with State law; •Imposing a surcharge for dropping coverage and subsequently reapplying if permitted by State law; •Instituting rules to help prevent dumping by employers to the extent permitted by State law; •Closing the block of business for current child-only policies if permitted by State law; and •Selling child-only policies that are self-sustaining and separate from closed	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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		child-only books of business if permitted by State law. In addition, some States are considering legislation that would require individual-market issuers that offer family coverage to also offer child-only policies. This approach could increase the options for families with healthy as well as sick children, and would lower the risk of adverse selection. The Administration would welcome this and other State actions that ensure access to health plans by families with children and prevent adverse selection in the market.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q7:** In some States with guarantee issue, to limit adverse selection, open enrollment periods are set for a particular time of the year, required to be used by all issuers, and, in some cases, are the only time when issuers can sell policies. Would the Administration consider adopting such a policy?	**A7:** As clarified earlier, issuers and States can already choose to use open enrollment periods consistent with existing regulations. To require a uniform open enrollment period for child-only policies would require a change in the existing regulations. The Administration would consider making such a change if it would result in issuers continuing to sell child-only plans.	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html
Enrollment of Children Under 19 Under the New	**Q8:** May carriers cancel or non-renew	**A8:** No. Under federal and state laws – pre-dating the Affordable Care Act – all	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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Policy That Prohibits Pre-Existing Condition Exclusions	children currently insured under child-only coverage due to a pre-existing condition, while continuing to renew coverage only for healthy children?	policies in the individual health insurance market are guaranteed renewable. In addition, the Affordable Care Act (by adding section 2712 of the Public Health Service Act) expressly prohibits carriers from rescinding coverage except in cases of fraud or intentional misrepresentation of material fact. Children under age 19 with pre-existing conditions who have child-only coverage may therefore maintain their coverage so long as that coverage is offered.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q9:** May either a state or HHS establish a uniform open enrollment period during which all insurers would be required to accept a child who applies, regardless of any pre-existing condition?	**A9:** HHS does not have the authority to establish a uniform open enrollment period without adopting a regulation that would expressly establish such a period. The Administration would consider making such a regulatory change if it would result in issuers selling new child-only plans, as explained in Q7 posted on September 24, 2010. States typically have the authority to promulgate bulletins or emergency regulations establishing uniform open enrollment periods relatively quickly. Some states, including California, Colorado, Ohio, Oregon, South Dakota, and Washington, have already established such periods, and others are considering doing so. HHS welcomes the state-based establishment of such periods to the extent that they expand options for families. If HHS were to establish a	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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		uniform open enrollment period in the future, it would anticipate accommodating states that have enacted their own uniform open enrollment periods.			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q10:** In states that have established uniform open enrollment periods, under what, if any, circumstances may families purchase child-only coverage for their children during the remainder of the year?	**A10:** If a child has had at least 18 months of prior creditable coverage (or has had continuous creditable coverage since a date within 30 days of birth) and loses group health coverage, he/she is a HIPAA-eligible individual and is guaranteed access to individual coverage without regard to a pre-existing health condition. The child must be allowed to apply for HIPAA-mandated coverage within 63 days after losing coverage. In many states, this coverage would be provided by a state high risk pool. Additional circumstances like the birth of a child or adoption may also be circumstances in which families may purchase child-only coverage for their children outside of open enrollment periods, depending on state law. These policies pre-date the Affordable Care Act.	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q11:** May an issuer that has an open enrollment period during which it enrolls children under age 19 with pre-existing conditions, medically	**A11:** No. Issuers that have an open enrollment period may not decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period while enrolling children under age 19 without such conditions. Depending on state policies regarding open enrollment periods,	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html

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	underwrite during the rest of the year and decline to enroll children under age 19 with pre-existing conditions outside of the open enrollment period?	issuers must either (i) enroll all children under age 19, regardless of pre-existing conditions, at all times, including outside the open enrollment period; or (ii) enroll all children under age 19, regardless of pre-existing conditions, during the open enrollment period, but decline to enroll all children under age 19 outside the open enrollment period, with exceptions described in Q10. Even for children who qualify for exceptions to enrollment during open enrollment periods, issuers may not decline enrollment due to a pre-existing condition. States may set one or more open enrollment periods for coverage for children under age 19, but cannot allow insurers to selectively deny enrollment for children with a pre-existing condition while accepting enrollment from other children outside of the open enrollment period(s).			
Enrollment of Children Under 19 Under the New Policy That Prohibits Pre-Existing Condition Exclusions	**Q12:** Does the pre-existing condition policy for children under age 19, and the clarifications in these "frequently asked questions," apply to the family policies as well as child-only policies?	**A12:** Yes.	FAQ October 13, 2010	CCIIO	http://www.cms.gov/CCIIO/Resources/Files/factsheet.html
Plan Management	**Q1:** How should the	**A1:** We will be collecting accreditation	FAQ April 8,	CMS	https://www.regtap.info/uploads/library/

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Webinar: Accreditation	National Committee of Quality Assurance (NCQA) / Utilization Review Accreditation Committee (URAC) accreditation templates be filled out if we are in the first year of the accreditation process?	information only from issuers that are currently accredited by NCQA and/or URAC on their commercial, Medicaid and/or Exchange market, if applicable. See 45 CFR 155.1045, which can be found at 78 FR 12865. Issuers that are in the process of receiving accreditation but are not yet accredited should mark "No" (that they are not accredited) in the accreditation section of the QHP application and should not fill out the NCQA/URAC templates.	2013		QHP_FAQs_040813.pdf
Plan Management Webinar: Accreditation	**Q2:** Once QHP Issuer Applications have been submitted, what is the process health plans should follow to report that Exchange products have received NCQA/URAC accreditation and when will this information be posted to the website? For example, if a health plan is scheduled to undergo an NCQA/URAC review in June and/or July and receives accreditation by September, how soon	**A2:** At this time, HHS is only accepting accreditation information from currently accredited issuers. Issuers that are not accredited at the time of submitting their QHP application should mark “No,” that they are not accredited, on the Accreditation section of the application. If you receive an accreditation status after the application closes, you should notify HHS and during the resubmission window you may submit your new accreditation information. For more information on this process, see pages 10-12 of the final Letter to Issuers on Federally-facilitated and State Partnership Exchanges (Issuer letter), published on the CCIIO website on April 5, 2013, at http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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	will that update be posted to the website?				
Plan Management Webinar: 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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Accreditation	**Q5:** For an issuer offering products during Federally-facilitated Exchange (FFE)/Partnership Exchange open enrollment in 2013 and not holding existing National Committee of Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC) accreditation, on or before what date	**A5:** Issuers without existing accreditation that offer a product as part of an FFE or Partnership Exchange in 2014 (open enrollment in 2013) must be accredited on QHP policies and procedures 90 days prior to 2014 open enrollment in order to be certified for the 2015 coverage year.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	must it be awarded accreditation by URAC or NCQA to allow its Quality Health Plans (QHPs) to continue participation on the Exchange?				
Plan Management Webinar: Accreditation	**Q6:** Must accreditation be completed before the QHP issuer's second year of certification, but not before the third year of certification?	**A6:** The issuer must be accredited on the QHP policies and procedures before the issuer's second year of certification, and must continue to be accredited on the policies and procedures in the third year of certification. The issuer must obtain full accreditation (in accordance with 45 CFR 156.275) by the fourth year of certification.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Accreditation	**Q1:** I am in the process of accreditation, and I have CAHPS data. Can I submit the CAHPS data?	**A1:** As stated in the "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," available on the CCIIO website at: http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf, for the 2014 coverage year, an Exchange website will only display selected CAHPS survey results from an issuer's accredited product lines when these existing data are available for the same QHP product types and adult/child populations. If applicable CAHPS data are not available through existing accreditation, the Exchange website will display a neutral statement such as "No data available." Please see Chapter 1,	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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		Section 2 of the Issuer Letter for more details.			
Plan Management Webinar: Accreditation	**Q7:** If an issuer is submitting a QHP application for a State-based Exchange through SERFF, and the State is not requiring the NCQA and URAC templates, does it need to submit the NCQA and URAC templates to SERFF in order to pass validation of the SERFF application?	**A7:** Issuers in State-based Exchanges should comply with the requirements for accreditation data collection that have been specified by the State-based Exchange. Issuers who are submitting QHP applications through SERFF for a State-Partnership exchange do not need to submit the Accreditation templates. Issuers that are submitting QHP applications through SERFF may also contact the NAIC for information about SERFF-specific requirements.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q3:** What are the QHP certification submission window dates? Is this different for the Federally-facilitated Exchanges (FFEs) and State Partnership Exchanges (SPEs)?	**A3:** We expect that the QHP Application window in the FFE will be April 1-30, 2013. All parts of the applications are due at that time. In the SPE, the State will define the timeline for application submission. For more information on this, please reference chapter two of the draft issuer letter.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q4:** What data elements will be part of the certification process? In an earlier call, HHS indicated that there are elements that will not be part of the	**A4:** All QHP Application final data elements and definitions can be viewed in the QHP Certification PRA package, OMB Control Number 0938-1187, available at http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201303-0938-004. The specific part of the certification	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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	certification and can be adjusted. For example, the network URL could be changed within the templates and not have an impact, because it was not an element that was under final approval.	process that this question speaks to is Plan Preview, scheduled for late August. Issuers will only be allowed to submit corrections to inaccurate data once they a) contact the FFE with the data inaccuracy concern and b) receive confirmation that they are allowed to resubmit the data. Only data that does not cause a "re-review" of the application, such as the network URL, will be eligible for correction.			
Plan Management Webinar: 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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: QHP Certification/Review Process	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q3:** Will there be a way to withdraw plans from the QHP certification process after the window closes but before	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	open enrollment?	the issuer offers all required QHPs given the change/withdrawal.			
Plan Management Webinar: QHP Certification/Review Process	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: QHP Certification/Review Process	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q1:** Will there be an opportunity to update the URL for provider networks after the	**A1:** As included in the Letter to Issuers (Table 2.1 Key Dates), issuers will have the opportunity to review data during the plan preview period and submit data	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	initial application period?	corrections (this is tentatively scheduled from August 22 –August 26). URL updates/corrections can be made at that time. The Letter to Issuers can be found at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf			
Plan Management Webinar: QHP Certification/Review Process	**Q2:** At what level does the organizational chart need to be submitted?	**A2:** This data needs to be submitted at the issuer applicant level.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q3:** What should issuers fill in for a Network ID, Service Area ID, and Formulary ID?	**A3:** Network IDs, Service area IDs, and Formulary IDs are internal system generated IDs. In each template you have the ability to generate these IDs. You must assign networks the same numbers as those assigned in the Network ID and Benefit templates.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q4:** Do the sections of the application have to be completed in order?	**A4:** No, the sections may be completed in any order.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
	Q57: When will the draft QHP Agreement be available for issuers to review?	**A57:** The draft QHP Agreement is expected to be released mid-summer.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q58:** Can an issuer request that a plan be certified and not placed on the Exchange?	**A58:** All "certified" plans will be placed on the Exchange. An issuer can withdraw the plan before final certification by contacting the Helpdesk before signing the agreement.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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Plan Management Webinar: QHP Certification/Review Process	**Q59:** When will there be dedicated content support for questions as issuers go through the QHP application process?	**A59:** The official Account Manager role is not yet available. The Helpdesk is the best mechanism to direct a question to the right expert. There will be more FAQ calls and open Q&A calls. The QHP Application Support and Q&A series is scheduled on Thursdays during the month of April. The HIOS calls will also respond to QHP questions on Wednesdays. As questions are coming into the Helpdesk, or submitted via REGTAP and the associations, FAQs will be compiled.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q60:** How will issuers be able to confirm that their data will display correctly?	**A60:** Testing will be similar to the Plan Finder post-submission testing and validation; essentially, issuers will have the opportunity to run rate quotes to check that business rules are functioning properly. As noted in the Letter to Issuers on Federally-facilitated and State Partnership Exchanges in Chapter 2 (http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf), there will be a resubmission window in June to address deficiencies. There will be a Plan Preview period in late August to run and check the rates. Issuers that identify a problem can contact the Helpdesk. If the issue identified does not trigger re-review of the QHP application, issuers will be allowed to resubmit. Issuers in the FFE will conduct that resubmission through HIOS; issuers in the State Partnership	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		Exchange (SPE) will conduct that resubmission through the System for Electronic Rate and Form Filing (SERFF) and SERFF will transmit that change into HIOS.			
Plan Management Webinar: QHP Certification/Review Process	**Q17:** Will issuers be required to file a separate network name for products that have embedded dental?	**A17:** Issuers are not required to file a separate network for products that have embedded dental. The Network ID for a network with dental providers can be used for both QHPs with embedded dental and QHPs without embedded dental. However, if the issuer would like to offer a QHP with a network including dental providers, and a second QHP with a network that excludes those providers, then the issuer will need to set up two different network IDs.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q18:** The Q&As released on April 8, "Plan Management Webinar Frequently Asked Questions, Frequently Asked Questions (FAQs) # 1" include information (Q4) about flexibility for changing URLs during plan preview. How will issuers submit corrections to inaccurate data? What confirmation is required that a	**A18:** Changes to network URLs or plan marketing name are not criteria for certification and may therefore be changed. During the resubmission window, the issuer is free to resubmit the Network ID template with changes to the network URLs, or the plan and benefits template with changes to the marketing name. During plan preview, issuers will need to have data changes approved by calling the help desk and indicating the change. The issuer will receive confirmation that the change will be allowed from the help desk. Changes that do not trigger re-review, including network URL and plan marketing name changes, will always be	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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	change will be allowed?	allowed, but still must be verified with the help desk.			
Plan Management Webinar: QHP Certification/Review Process	**Q19:** We are looking at submitting multiple networks for QHP certification. If we later decide we would like to only use one of the networks, can we pull the other network and the products associated with that network? What is the latest date we can decide to not use a network?	**A19:** There is no requirement to use all networks that an issuer submits. Issuers will have the opportunity to withdraw QHPs before agreement signing in late September. If an issuer withdraws all QHPs associated with a given network, there is no need to remove the unused network from the QHP Application.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q20:** For the 4/30 FFE submission in HIOS, we know the opportunity to respond to deficiencies will occur the week of 6/17. What exactly can plans change during this time? We know we can respond to deficient items, upload accreditation data, and submit additional justifications. What else can be changed?	**A20:** In addition to responding to deficiencies, updating accreditation data, and submitting justifications, issuers may also change data that are not related to the certification standards (e.g., plan marketing names, network URLs, contact information). Issuers may also resubmit in response to state feedback at any time allowed by the state (including outside of the official FFE resubmission window), provided that those changes are made only to fields directly impacted by the State review.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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Plan Management Webinar: QHP Certification/Review Process	**Q21:** Our URLs will not validate if they have a dash. How should we submit this data?	**A21:** The next versions of the templates will allow hyphens in the URL name. Issuers may submit templates now with placeholder URLs and will be able to change URLs through the Resubmission or Plan Preview processes.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q1:** Does a certification year equal exactly 12 months?	**A1:** In the Federally-facilitated Exchange, a certification year is 12 months. At 45 CFR 155.1075, we state that "an Exchange must establish a process for recertification of QHPs." For the FFE, we have established that QHP certification is for 12 months, as generally discussed in various guidance documents, including the Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. We note that this does not apply to CO-OP and Multi-State Plans.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q2:** What if an issuer is unable to correct a deficiency within the resubmission window? For example, what if the problem is with the certification of good standing?	**A2:** If the deficiency identified requires follow-up with the State or other parties that cannot be completed in the time allowed for resubmission, the issuer should submit an explanation describing the activities being conducted to address the deficiency.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: QHP Certification/Review	**Q3:** What supplementary documentation is	**A3:** If the issuer is in compliance with State solvency requirements and is not under any corrective action related to	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Process	needed for the "Good Standing" section?	financial review, then no supporting documentation is required. Please see Chapter 4 of the Instructions for a description of supporting documentation and justifications required if an issuer is out of compliance or under corrective action.			
Plan Management Webinar: QHP Certification/Review Process	**Q4:** Is a final provider directory required at the time of application or may updated provider directories be submitted after the QHP application is submitted?	**A4:** Issuers are required to provide a URL link to their provider directory at the time of submission. However, the sites themselves do not need to be live until open enrollment. Also, issuers will have the opportunity to correct any errors to URLs that are provided at the time of submission during the plan preview period.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q5:** When can issuers update their provider directories?	**A5:** If an issuer has an error in the network URL, the issuer can submit a correction during the resubmission window or during plan preview in late August. No changes will be accepted after Plan Preview.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q6:** Where do issuers submit plan materials such as evidence of coverage?	**A6:** Supplemental documentation such as evidence of coverage can be submitted using the upload "supplemental document" feature in the Benefits & Service Area module of the QHP Application. Users may refer to Plan and Benefits user guide for additional information on submitting supplemental documents.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management	**Q1:** Can an issuer	**A1:** As long as a plan originally	FAQ May 3,	CMS	https://www.regtap.info/uploads/library/

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Webinar: QHP Certification/Review Process	remove a plan from the Exchange, but still offer it off-Exchange?	submitted as "Both", the issuer can withdraw it from on the Exchange and still offer it off the Exchange, subject to meeting any applicable state approval requirements. However, HHS encourages issuers to only submit applications for plans that it currently intends to offer on the Exchange.	2013		PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q2:** What are the specific actions that an issuer attester must perform?	**A2:** The attester will be required to agree to the final plan offerings list, which will contain the QHPs the FFE is recommendation for certification, as well as sign the QHP Agreement. The submitter and validator will provide the response to the Program Attestations during the initial QHP submission. The Attester's input is not required during the initial submission window.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q3:** Where can issuers view the QHP Agreement?	**A3:** HHS plans to release a copy of the agreement by mid-summer.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: QHP Certification/Review Process	**Q4:** Do products and/or networks need to be approved by the applicable state regulatory agency prior to April submission?	**A4:** 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	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		certification, QHP issuers 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.			
Plan Management Webinar: Dental	**Q5:** Will there be benefit and rate templates specific for stand-alone pediatric dental plans?	**A5:** For the FFE, we are planning to use a modified benefits template for stand-alone dental plans.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Dental	**Q6:** If there is a stand-alone dental plan offered on the exchange, does a QHP still need to offer pediatric dental benefits as part of its Essential Health Benefits (EHBs)?	**A6:** No. Please see 45 CFR §155.1065(b). In prior rulemaking, we sought information from issuers regarding whether they planned to offer stand-alone dental plans, and we collected this information through a PRA package, OMB Control Number 0938-1174. Further information on this voluntary dental reporting is available at http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf on CCIIO's website.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Dental	**Q7:** Do plans offered outside of the Exchange have to have pediatric dental embedded in the medical benefit? Does this also apply	**A7:** Plans offered outside of the Exchange must offer the full set of essential health benefits. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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	in the small group market outside of the Exchange?	Exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. See the comment/response discussion for §156.150 of the EHB final rule at 78 FR 12852, available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.			
Plan Management Webinar: Dental	**Q8:** Can stand-alone dental plans submit actuarial certification to demonstrate that they meet the high or low Actuarial Value (AV)?	**A8:** Yes, according to §156.150(b)(3) of the final EHB rule, found at 78 FR 12869, in order to demonstrate that stand-alone dental plan AV standards are met, an actuarial certification is required.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Dental	**Q9:** Does the out-of-pocket maximum include both medical and dental benefits if pediatric dental benefits are embedded in the medical plan? Having a separate	**A9:** Please refer to §156.150 of the EHB final rule for further information on stand-alone dental plans. If pediatric dental benefits are embedded in the QHP, then the one out-of-pocket maximum for the QHP applies.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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	out-of-pocket maximum for medical and dental has been suggested.				
Plan Management Webinar: Dental	**Q10:** When the Advanced Payment of Premium Tax Credit (APTC) is calculated, will it balance for the missing cost of pediatric dental if the second lowest silver plan is a medical only plan?	**A10:** If the second lowest cost silver plan for a particular taxpayer is a QHP that does not include the pediatric dental EHB, and the taxpayer chooses to enroll in the second lowest cost silver plan, the APTC will not cover the cost of the pediatric dental EHB, even if the taxpayer also enrolls in a stand-alone dental plan. However, if the taxpayer enrolled in a QHP and stand-alone dental plan that, together, were lower in cost than the second lowest cost silver plan, the APTC could cover some or all of the cost of the pediatric dental EHB covered by the stand-alone dental plan, provided that the total APTC does not exceed the limit established by the second lowest cost silver plan. Please see the IRS final rule at 77 FR 30377 for a description of this. The rule is available at http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Dental	**Q12:** What is the definition of medically-necessary orthodontia?	**A12:** Issuers will be responsible for developing standards to define medically-necessary orthodontia.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Dental	**Q13:** Do the rating reforms apply to stand-alone dental	**A13:** Stand-alone dental plans are not subject to Parts A and B of the Public Health Service Act. Please reference	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	plans?	Chapter 4 of the Letter to Issuers referenced above for a more detailed explanation.			
Plan Management Webinar: Dental	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Dental	**Q12:** Is dental subject to the same minimum thresholds as medical in regards	**A12:** Yes, dental plan issuers are subject to the Essential Community Provider thresholds. See 45 CFR §156.235 for more information on Essential	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	to Essential Community Providers (ECPs)?	Community Providers. More information on the thresholds can be found in the Letter to Issuers in Federally-facilitated and State Partnership Exchanges on the Center for Customer Information and Insurance Oversight (CCIIO) website at: http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. The list of ECPs that provide dental services is available here: https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu			
Plan Management Webinar: Dental	**Q13:** Will there be a dental ECP list?	**A13:** Yes, ECP providers that cover dental services will be identifiable. The list of ECPs that provide dental services is available at: https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Dental	**Q14:** If someone enrolls in the pediatric oral Essential Health Benefit (EHB) offered through a stand-alone dental plan (SADP) during the normal open enrollment process and then drops the coverage mid-year, will he or she be	**A14:** Yes, when provided under a separate policy or contract, limited scope dental benefits are excepted benefits, as defined by PHS Act section 2791, and thus not subject to the requirements of the PHS Act, including section 2702 guaranteed availability standards [Please refer to the Letter to Issuers in Federally-facilitated and State Partnership Exchanges for more information: http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_040520	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	allowed to re-enroll during the next open enrollment period with the same company, or can plans include and enforce a lock-out period (for example 2 years) to discourage this anti-selection behavior?	13.pdf.			
Plan Management Webinar: Dental	**Q56:** Is an issuer required to have a health plan with the pediatric dental EHB embedded for consumers who have not purchased a stand-alone dental plan?	**A56:** The answer depends on whether the health plan is offered inside or outside of the Exchange. Inside of the Exchange: As stated in the Issuers of Stand-alone Dental Plans: Intent to Offer in FFE States document available at: http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf, "The Affordable Care Act also permits a health plan that does not provide the pediatric dental EHB to be certified as a qualified health plan (QHP) eligible for Exchange participation so long as such Exchange offers at least one stand-alone dental plan. In order to allow QHP issuers to exercise the statutory option to omit the pediatric dental essential health benefit (EHB), CCIIO established a voluntary reporting process for dental issuers to communicate their intent to offer pediatric dental EHB through	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		stand-alone dental plans in Exchanges. Given that there are at least three issuers planning to offer such plans in both markets statewide, we believe that HHS can reasonably expect there to be sufficient stand-alone dental coverage to permit QHPs in the FFE in these states to omit the pediatric dental EHB if they choose to do so." The EHB final rule, published 2/25/13 at 78 FR 12834, further clarifies: "Nothing in this rule requires the purchase of the full set of EHB if the purchase is made through an Exchange. Thus, in an Exchange, someone (with a child or without) can purchase a QHP that does not cover the pediatric dental EHB without purchasing a stand-alone dental plan." Outside of the Exchange: As stated in the EHB final rule available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf: "The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside of the Exchange as it does in section 1302(b)(4)(F) of the Affordable Care Act for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased			

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		stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange- certified stand-alone dental plan offered outside an Exchange, the issuer would not be found non-compliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. We note that the stand-alone dental plan would have to be an Exchange-certified stand-alone dental plan to ensure that it covered the pediatric dental EHB. This alternate method of compliance is at the option of the medical plan issuer, and would only apply with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan."			
Plan Management Webinar: Dental	**Q5:** Outside of the Exchange, does the medical plan need to provide dental benefits if an individual provides	**A5:** No. Outside of the Exchange, the issuer must have reasonable assurance that the individual has purchased exchange-certified stand-alone dental coverage that covers the pediatric EHB requirement, as noted in the preamble to	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	reasonable assurance to an issuer that he/she has already purchased an exchange certified stand-alone dental plan that covers the pediatric EHB?	the final rule on EHB at 78 FR 12853. This assurance could be obtained by requiring proof of coverage from the individual or establishing a method of confirming coverage directly with the stand-alone dental plan. The method of obtaining assurance is at the discretion of the issuer.			
Plan Management Webinar: Dental	**Q6:** Can the Exchange-certified stand-alone dental plan and medical plan have separate deductibles and out-of-pocket maximums (provided the Exchange-certified stand-alone dental plan amounts are determined to be "reasonable")?	**A6:** According to the Letter to Issuers, under 45 CFR 156.150, rather than meeting the specific dollar limits that apply to comprehensive medical QHPs, stand-alone dental plans offered inside an Exchange will be required to demonstrate to the Exchange (FFE or otherwise) that they have a reasonable annual limitation on cost-sharing in place. The final rule also clarified that the Exchange is responsible for determining the level for "reasonable." For 2014 in the FFE, the annual out-of-pocket maximum for a stand-alone dental plan is $700 for one child and $1,400 for two or more children. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q7:** For off-Exchange business, if an individual does	**A7:** Outside the Exchange, the issuer should embed dental services including pediatric dental coverage if the issuer is	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	not purchase an Exchange-certified stand-alone dental plan, does the issuer have to embed the pediatric dental benefit into the medical plan?	not reasonably assured that the individual is enrolled in an Exchange-certified stand-alone dental plan.			
Plan Management Webinar: Dental	**Q8:** If the pediatric benefits have to be embedded, do they have to track to a single combined deductible and out-of-pocket max?	**A8:** According to the EHB Final Rule , when the pediatric dental benefit is embedded in a health insurance plan subject to standards set forth in 45 CFR 156.130 and 156.140, HHS does not distinguish it from other benefits with respect to AV and cost-sharing requirements. The dental benefit can have a separate deductible and/or maximum out-of-pocket as long as the total combined with medical does not exceed what is allowed by the statute.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q9:** Is there an AV Calculator for stand-alone dental?	**A9:** As described in 45 CFR 156.150(b), a stand-alone dental plan may not use the AV Calculator, and instead must demonstrate that the stand-alone dental plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70 percent or a high level of coverage with an AV of 85 percent, and within a de minimis variation of +/-2 percentage points. In order to meet this standard, the AV level of coverage for stand-alone dental plans must be certified by a member of the American Academy of Actuaries using	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		generally accepted actuarial principles.			
Plan Management Webinar: Dental	**Q10:** Will dental plans complete the Unified Rate Review Template?	**A10:** As stated in the Letter to Issuers, stand-alone dental plans will not need to complete the unified rate review template. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q11:** If an issuer offers a plan with pediatric dental carved out and an identical plan that includes pediatric dental coverage, should these plans have the same actuarial value for metal-level determination? Should issuers adjust the AV results for pediatric benefits?	**A11:** Although they are not separate calculator inputs, the AV Calculator does include both pediatric dental and vision claims as part of the standard population. However, a plan's inclusion of the pediatric dental benefit generally will not result in a material difference in AV because both cost and utilization are low in the standard population. Therefore, in most cases there will be no need to adjust the AV results.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q12:** For an integrated pediatric dental and medical plan, is it permitted to establish two separate buckets for the out-of-pocket limit for medical and	**A12:** Yes, that would be permitted.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	dental coverage as long as the total out-of-pocket limit does not exceed the QHP limit?				
Plan Management Webinar: Dental	**Q13:** What certification, if any, is required for a stand-alone dental plan?	**A13:** Please refer to Chapter 4 of the Letter to Issuers for details on the certification requirements. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q14:** Where can issuers find information about stand-alone dental plans submitting intent to participate in FFEs?	**A14:** Information about the intent to participate in the FFE by stand-alone dental plan issuers can be found here: http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q15:** When will the stand-alone dental plan templates be finalized?	**A15:** As stated in the Letter to Issuers: "Stand-alone dental plans will generally use the same QHP Application, but will complete and submit the application on an adjusted timeline. Some portions of the QHP certification application require modifications to accommodate the limited scope of stand-alone dental plans. For the 2013 QHP certification cycle, HHS anticipates that the draft plan benefits template will be ready for stand-alone dental plans by May 1." The Letter to Issuers on Federally-facilitated	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf			
Plan Management Webinar: Dental	**Q16:** What is the submission window for stand-alone dental plans?	**A16:** As stated in the Letter to Issuers: "Issuers of stand-alone dental plans can begin to work on completing the other QHP templates in advance of May; however, final submission of stand-alone dental plan applications will need to occur between May 15 and May 31." The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Dental	**Q17:** Can the required pediatric dental EHB be a stand-alone dental plan?	**A17:** The pediatric dental EHB can be offered through a stand-alone dental plan in the Exchange.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Transactions	**Q11:** Have specifications on the Edge Servers required by issuers been released yet?	**A11:** 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, we HHS is conducting a short series of educational webinars focused on details of the distributed data approach. You can	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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		register for these sessions at 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 we plan to conduct followed by user group sessions and additional operational policy guidance.			
Plan Management Webinar: Transactions	**Q12:** If the consumer enrolls through the FFE, will the FFE collect the binder payment (the payment that binds the individual to the coverage)? If not, how will issuers be notified?	**A12:** The FFE will not aggregate premiums for issuers in 2014. However, the FFE will generate an 834 enrollment transaction upon plan selection and send that initial enrollment transaction to the issuer to effectuate the enrollment and to collect the appropriate portion of the premium for which the individual is responsible. The 834 enrollment transaction will detail the enrollment information, including total premium amount, with a breakdown of the APTC amount and the remaining individual responsibility portion of the premium for the enrollment group. This will include a breakdown of the APTC amount and the remaining individual responsibility portion of the premium for the enrollment group. The issuer will be responsible for collecting the individual responsibility portion of the premium. This is depicted as the Total Responsibility Amount of the 2750 loop in the FFE 834 companion guide. (The	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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		companion guide can be found at http://cciio.cms.gov/resources/files/companion-guide-for-ffe-enrollment-transaction-v1.pdf.)			
Plan Management Webinar: 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. 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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Transactions	**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	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	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?				
Plan Management Webinar: Transactions	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Transactions	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Transactions	**Q24:** Do issuers need to be QHP	**A24:** The reinsurance program applies to all applicable individual market	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	certified if they only offer off-Exchange products, but still want to be able to receive the 3Rs (reinsurance, risk adjustment and risk corridor)?	issuers inside and outside of the Exchange, and the risk adjustment program applies to applicable individual and small group market issuers inside and outside of the Exchange. Products outside of the Exchanges do not need to be QHPs in order to take part in these programs. The risk corridor program is only applicable to QHPs.			
Plan Management Webinar: Transactions	**Q25:** Is the data submission process for Medicare applicable to the Edge Server?	**A25:** The data and submission process on the Edge Server is specific to the reinsurance and risk adjustment programs specified in the ACA (e.g., private insurance and not Medicare). Medicare data should not be submitted to the Edge Server.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Transactions	**Q26:** Per the final Payment Notice, the initial Risk Adjustment model will exclude prescription drug data. However, the final Payment Notice states that claims and encounter data for prescription drugs are required to be submitted on the Edge Server. Why is this?	**A26:** The transitional reinsurance program considers pharmacy claims as reinsurance-eligible claims. All reinsurance-eligible claims will be included during the payment calculation process on the Edge Server for the HHS-operated reinsurance program.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Transactions	**Q27:** For the zero cost sharing plan variation of a closed-	**A27:** A zero cost sharing plan variation, as defined at 45 CFR 156.420(b)(1), is a variation of a QHP with all cost sharing	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	panel HMO QHP, does the cost sharing for out-of-network services need to be eliminated?	eliminated. However, cost sharing is defined at 45 CFR 155.20 to be any expenditure required by or on behalf of an enrollee with respect to Essential Health Benefits, including deductibles, coinsurance, copayments, or similar charges, but excluding premiums, balance billing amounts for non-network providers, and spending for non-covered services. Therefore, if the QHP is a closed-panel HMO that does not cover services furnished by a provider outside of the network (i.e. cost sharing for services provided by an out-of-network provider is 100%), the spending, or cost sharing, for these non-covered services would not need to be eliminated for the zero cost sharing plan variation associated with this QHP, and should be entered as it would be for non-covered out-of-network services under the corresponding standard plan. For covered benefits that are not Essential Health Benefits, the coinsurance and copays must be the same as the associated standard plan (despite the template auto-populating them with 0's). For additional information, please consult the final HHS Notice of Benefit and Payment Parameters, published March 11th 2013.			
Plan Management Webinar: Transactions	**Q11:** Is there any information available regarding how to	**A11**: Information about how to register as a trading partner and details about the network requirements for establishing	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	register as a trading partner? Are hardware, software, or network requirements available for processing transactions timeframe for testing send and/or receive transactions?	connectivity, meeting security requirements, and processing transactions is forthcoming. We will also be providing information about the testing schedule in the near future. This applies to issuers that will be approved to participate in the FFE as well as in SBEs.			
Plan Management Webinar: Transactions	**Q12:** Which issuer should submit reinsurance contributions for enrollees in point-of-service plans when the plan provides health insurance coverage through two affiliated issuers?	**A12:** When a point-of-service enrollee is covered by two affiliated issuers, the enrollee need only be counted once for reinsurance contribution purposes. The issuers should coordinate to ensure the total reported is an unduplicated aggregate enrollment count for all enrollees. Reinsurance contributions should be made for the point-of-service enrollees by the issuer of the plan through which the enrollees would receive the majority of benefits, as reasonably determined by the issuers. The issuers must submit to HHS documentation substantiating the enrollment count pursuant to 45 CFR 153.400(b), including references to the issuer that counted the point-of-service enrollee in their annual enrollment count, and the issuer that did not. As an example, assume that Comprehensive Health Insurance Company, Inc. offers a point-of-service product in the	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		individual market in State X. The point-of-service product includes a PPO option written by Comprehensive Health Insurance Company, Inc. (Comprehensive Health) and an HMO product written by Comprehensive Health Insurance HMO, Inc. (Comprehensive HMO), which offers HMO products in the individual market in State X. Assume that there are 1,000 enrollees in State X in the point-of-service product, and therefore, both Comprehensive Health and Comprehensive HMO, which are under common control, have the same 1,000 individuals as enrollees. The 1,000 enrollees receive the majority of their benefits from Comprehensive HMO. In this scenario, Comprehensive HMO would make reinsurance contributions with respect to the 1,000 enrollees, whereas Comprehensive Health would omit these 1,000 enrollees from their enrollment count.			
Plan Management Webinar: Transactions	**Q13:** For purposes of reinsurance payments, how will claims covered by a point-of-service plan be allocated when the plan provides health insurance coverage through two affiliated issuers?	**A13:** HHS is in the process of working through the payment processes that would apply to point-of-service plans provided through two affiliated issuers. We will provide further guidance specifying how claims for point-of-service products will be aggregated for reinsurance payment purposes in those cases.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q13:** Will there be a training session dedicated to FF-SHOP, including the interactions between the issuers, SHOP, and the aggregator(s)? Will there be a complete data dictionary for the files that will be exchanged between the FF-SHOP and the issuer and the aggregator and the issuer?	**A13:** We are planning to conduct dedicated sessions on SHOP enrollment and payment matters involving premium aggregation services and will share a complete data dictionary for payment file transfers.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q14:** How many eligible employees may a SHOP group have?	**A14:** 100 full-time equivalent employees, although States may keep the upper limit of their small group market at 50 for 2014 and 2015; we anticipate that virtually all States will keep their upper limit at 50 for the first two years. See 45 CFR 155.20 for a definition of "small employer," and 45 CFR 155.710(b) for its applicability to the SHOP.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q15:** Are child-only plans required on the SHOP Exchange?	**A15:** Yes, offering a child-only option is a requirement under section 2707(c) of the Affordable Care Act for enrollees under the age of 21, or in the case of the SHOP, employees under the age of 21.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Small Business Health Options Program	**Q16:** If an employer with less than 20 employees signs up	**A16:** The SHOP follows the same Medicare Secondary Payer rules as the outside market. All else equal, a small	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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(SHOP)	through the SHOP, would an employee who is also on Medicare pay the same rate on the SHOP?	group rate does not differ based on Medicare eligibility. Please see 45 CFR 147.102.			
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q17:** Can families pick different plans in the SHOP exchange?	**A17:** For FFEs, pursuant to the proposed March 11 Notice of Proposed Rule Making (NPRM), (77 CFR 15553) an employer may only offer one plan to its employees in the first year of FF-SHOP operation. This proposal does not permit the scenario described in this question.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q18:** In States with an FFE, will the State definition be followed in States that define small group as 2-50 employees?	**A18:** Section 2791 of the PHSA defines the small group market for employers with 1 – 100 employees. Flexibility is provided to State-based Exchanges in 2014 and 2015 regarding the upper limit of the small group market (the state may reduce the upper limit to 50) and the method of determining employer size for the state's small group market - not regarding whether or not a group health plan exists. As described in the preamble to the Exchange Final Rule (77 FR 18398) A State-based SHOP may use both the numerical upper limit and the state method of determining employer size. The FF-SHOP will use the state's numerical upper limit (50 or 100) but must use the FTE method of determining employer size. States, State-based SHOPs, and FF-SHOPs	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		must use ERISA/PHS Act provisions that prevent a business without at least one common law employee from forming a group benefit plan (sole proprietors, certain S-corp shareholders, and family members of either are not common law employees).			
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q48:** Are individual market issuers (currently not a small group issuer) allowed to participate in SHOP to sell individual policies to small group employees?	**A48:** Only small group market products can be sold on SHOP.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Small Business Health Options Program (SHOP)	**Q49**: If a group is larger than the small group threshold and subsequently the size falls below the small group threshold, will the group be allowed to keep its existing products, or will it be required to purchase new products?	**A49:** An employer has the right to renew or continue in force coverage originally purchased in the large or small group market, even though the employer may no longer meet the definition of a large or small employer. If the employer voluntarily drops the coverage, however, that employer would only be able to purchase coverage in the relevant market (and the coverage would have to comply with the relevant market requirements). Please reference Insurance Standards Bulletin Series, Group Size Issues under Title XXVII of the Public Health Service Act, Transmittal 99-03, available at http://cciio.cms.gov/resources/files/Files2/10112011/hipaa_99_03_508.pdf.pdf.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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Plan Management Webinar: States	**Q15:** How do you envision the coordination process occurring between the FFE QHP filing and the State rate and policy form filing? What happens if the FFE approves the QHP application, but the State does not approve, or requires minor changes to the policy form?	**A15:** No product can be sold on any Exchange unless it is first approved for sale by the State Department of Insurance (DOI). For more information on our approach and state/FFE roles, please see the General Guidance on the FFE, published May 16, 2012, at http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf. In the FFE, the issuer will submit the QHP application to the FFE in the Health Insurance Oversight System (HIOS) and will also submit form filing as required by the State. Before an issuer signs a QHP Agreement for a certified QHP, the issuer will have to confirm that the QHP has been approved for sale by the State. If a plan is approved as a QHP but does not attain approval by the DOI, it will not be available on the Exchange.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q16:** Where a plan offers an EHB service in excess of the state benchmark (such as 30 visits as opposed to 15), how will visits 16 through 30 be treated with respect to both metal-tier actuarial value and the cost-sharing maximum?	**A16:** Any EHB/Benchmark services offered, even in excess of minimums of the benchmark, are considered EHB services and apply to the index rate and must be spread evenly across the risk pool. See §156.115(a)(1) and the preamble discussion at 78 FR 12843 regarding §156.115.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Health	**Q19:** Can a State adopt different	**A19:** No. As described in the EHB Final Rule published in the Federal Register	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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Benefits (EHB)	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?	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			

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		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.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q20:** As is mentioned in the Actuarial Value (AV) Calculator user guide, 100% general coinsurance rates should only be used for copay based plans, but in cases where the issuer is inputting a coinsurance based plan that has 100% coinsurance, what should the issuer input for the coinsurance rate?	**A20:** When inputting 100% coinsurance rate, the AV Calculator will attempt to calculate an effective coinsurance rate to apply, expecting a copay plan. However, if the plan is a 100% coinsurance plan and is not a copay-based plan, the plan should use 99.99% coinsurance rate as the effective coinsurance rate.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q21:** There is a provision that allows the annual deductible to exceed $2,000 if needed in order to get to the appropriate AV. Does this mean stand-alone dental EHB can have a	**A21:** A stand-alone dental plan may have a separate deductible amount and will not need to coordinate with the medical plan. Because AV levels are different for stand-alone dental plans, high of 85% and low of 70%, as established in 45 CFR 156.150, CCIIO does not currently expect that stand-alone dental plans will exceed allowable	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	separate deductible amount (dental standard example $50) that would not be subject to coordination of benefits with the medical EHB plan in order to achieve the required AV levels?	deductible amounts in the small group market in order to reach AV targets.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q22:** Should issuers provide information about optional riders that do not impact Essential Health Benefits (EHBs)?	**A22:** The FFE and State Partnership Exchange templates do not collect and will not display optional riders. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the FFM an issuer should submit two plans, one with and one without the rider. Depending upon the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFM website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q23:** What can be used as a source document for understanding the required benefits of the benchmark?	**A23:** The regulatory standard for plans wishing to offer EHB is that plans must offer benefits and limits that are substantially equal to the benefits and limits in the benchmark, as outlined in 45 CFR 156.115. The benefits available through the CCIIO website are a summary of the EHBs for each respective state. The CCIIO website	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		also includes an explanation of what is listed and how to review, and a document called "Guide to Reviewing Essential Health Benefits Benchmark Plans." In order to provide states, issuers, and others more information on the benchmark, the National Association of Insurance Commissioners (NAIC) has recently made more detailed benefit documents available. As published in the EHB final rule, EHB compliance is the responsibility of states regardless of Exchange type. We would encourage issuers to work with their enforcing state to further understand what enforcement or review for EHB will entail.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q23:** If the benchmark lists a benefit, does it need to be listed on the template as well? If an issuer don't list each and every benefit covered by the benchmark, will the issuer be deemed non-compliant?	**A23:** Please see the plan documents (Evidence of Coverage, Plan Benefits Summary, etc.) for more information regarding the particular items or services covered by the benchmark plan. As stated in the EHB final rule, published at 78 FR 12834, the benchmark plan defines the benefits. See, generally, 45 CFR 156.110 and 156.115. Moreover, an EHB plan is expected to be substantially equal to the benchmark pursuant to 45 CFR 156.115(a)(1), so you may not list every benefit but you would have to substitute or offer other benefits to be deemed substantially equal.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management	**Q24:** Can issuers	**A24:** Per 45 CFR 156.130(b)(3), "a	FAQ April 24,	CMS	https://www.regtap.info/uploads/library/

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Webinar: Essential Health Benefits (EHB)	have a small group plan at the silver level that exceeds the $2000/4000 deductible in some plan variations even if the issuer can reach the silver level with a $2000/4000 deductible (as long as the AV meets the silver level)?	health plan's annual deductible limit may exceed the annual deductible limit if the plan may not reasonably reach the actuarial value of a given level of coverage as defined in § 156.140 of this subpart without exceeding the annual deductible limit." However, for example, if you input a plan with a $2,000 deductible with a 75% coinsurance and $5,000 out-of-pocket maximum, subjecting all of the benefits to the deductible and the coinsurance, the AV will be within the silver range.	2013		PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q25:** How do maximum out-of-pocket limitations apply to large group plans providing coverage for both in and out-of-network services?	**A25:** Out-of-pocket amounts for covered services received from providers outside of the plan's network are not required to count towards the out-of-pocket limitations. As stated in 45 CFR 156.130(c), "[i}n the case of a plan using a network of providers, cost-sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network shall not count towards the annual limitation on cost-sharing (as defined in paragraph (a) of this section)." This would apply regardless of whether the plan expresses its out-of-pocket maximum separately for in- and out-of-network services, or as a unified amount for any services received. Only out-of-pocket amounts for covered services received from in-network providers would count towards the amount which is subject to the statutory/regulatory limitation.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		However, the plan would need to be able to track in-network cost sharing amounts in order to ensure that it is complying with the limitation.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q26:** If the benchmark plan includes waiting periods, can these be included in QHP offerings?	**A26:** If the benchmark plan has waiting periods (not to exceed 90 days) then the EHB plan can also have waiting periods, but keep in mind the EHB plan limits must be substantially equal to the benchmark plan limits.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q27:** The Missouri individual market "PlansBenefits.xlsm" template does not include "Applied Behavior Analysis Based Therapies," which is an EHB-benchmark plan benefit that the HIOS application collection system requires in order to validate a submission. What should issuers in Missouri do to ensure that they can submit their PlansBenefit.xlsm template in HIOS?	**A27:** To ensure that Missouri issuers can submit their applications in HIOS, prior to clicking "Create Cost Sharing Variances" on the Plans & Benefits ribbon, issuers should add the benefit "Applied Behavior Analysis Based Therapies" to the Benefits Package 1 tab of the PlansBenefits.xlsm template. This should be done by clicking "Add Benefit" on the Plans & Benefits ribbon, and completing all associated fields with the same information that populates for the Missouri SHOP (Small Group). As a reference, those data elements should be as follows: "Benefits = Applied Behavior Analysis Based Therapies," "Is this Benefit Covered = Covered," "Subject to Deductible (Tier 1) = Yes," "Subject to Deductible (Tier 2) = Yes," "Excluded from In Network MOOP = No," "Excluded from Out of Network MOOP = No." If an issuer has already clicked "Create Cost Sharing Variances," they should delete the Cost	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		Sharing Variances 1 tab and then "Create Cost Sharing Variances" on the Plans & Benefits ribbon.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q22:** For testing Mental Health parity, does the Mental Health and Substance Abuse category also include services in the office?	**A22:** Yes, parity does include office visits for services included under the definition of mental health or substance use disorder benefits.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q23:** Can issuers offer products off the Exchange that include EHB but do not meet the metal level?	**A23:** No. The Affordable Care Act requires issuers offering non-grandfathered health insurance coverage in the individual and small group markets both inside and outside the Exchange ensure that plans meet a level of coverage specified in Section 1302(a)(3) of the Affordable Care Act and defined in 45 CFR 156.140(b). Each level of coverage corresponds to an AV calculated based on the cost-sharing features of the plan.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q24:** When will issuers get more clarification about what "substantially similar" means with respect to benefits?	**A24:** An enforcing State (or HHS in non-enforcing states) will determine whether or not an EHB plan is substantially equal to the benchmark plan. As noted in the preamble to the final rule on EHB at 78 FR 12844, we seek to allow for flexibility of plan design. At this time, HHS does not expect to release additional guidance on this standard.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health	**Q25:** For FFEs, who is making the	**A25:** Enforcement of the requirement to cover EHB is governed by section 2723	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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Benefits (EHB)	assessment that the benefits are substantially equal?	of the PHS Act, which looks first to States for enforcement, then to the Secretary where a State has failed to substantially enforce the standard. If the State is enforcing the Affordable Care Act requirement, the State will make the assessment. If, however, the State does not enforce Affordable Care Act requirements, then HHS will make the assessment. Whichever entity makes the assessment will do so for the entire market (both inside and outside). The standards for the review are outlined in the Guidance on the State Partnership Exchange, posted to the CCIIO website on January 3, 2013 and available at http://cciio.cms.gov/resources/files/partnership-guidance-01-03-2013.pdf			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q26:** Is there a definition of "meaningful difference"?	**A26:** The Letter to Issuers provides further information and guidance on the meaningful difference standard. Please see pages 15 and 16 of the Letter to Issuers for more information. The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q27:** Will a metal plan qualify if prescription coverage is not included?	**A27:** Per 45 CFR 156.100, prescription benefits are one of the 10 benefit categories of EHB and therefore must be covered.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management	**Q28:** Are issuers	**A28:** Issuers are not required to provide	FAQ May 3,	CMS	https://www.regtap.info/uploads/library/

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Webinar: Essential Health Benefits (EHB)	required to provide the services outlined in 45 CFR 156.115 (d), even if they are on the Plans & Benefits Template marked as EHB?	the four services listed at 45 CFR 156.115(d) – routine non-pediatric dental; routine, non-pediatric eye exam services; long-term/custodial nursing home care; and non-medically necessary orthodontia -- (even if the benchmark covers those services) because those particular services are not EHB.	2013		PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q29:** The FEDVIP brochure lists a lot of specifics in terms of specific dollar amounts that are allowed. If a pediatric vision plan has an allowance, can it be a dollar allowance amount and would that be considered some sort of limit?	**A29:** The Affordable Care Act prohibits annual and lifetime dollar limits on EHB, so even if the FEDVIP brochure includes such limits, EHB plans cannot impose such limits. See 45 CFR 147.126.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q30:** Could a child who receives coverage for lenses and frames under pediatric vision benefit receive an additional benefit under our Lenses and Frames rider for the amount that isn't covered?	**A30:** Yes, issuers can offer riders to cover additional benefits beyond EHB.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health	**Q31:** Does the Mental Health parity	**A31:** Yes, all EHB plans must include mental health and substance use	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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Benefits (EHB)	requirement apply to both SHOP and individual markets?	disorder services and those must comply with parity. Per 45 CFR 156.115(a)(3), since EHB plans are sold in the small group and individual markets, that means parity is required in both markets.			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q32:** If a State's benchmark plan includes coverage for bariatric surgery, does the QHP have to cover bariatric surgery?	**A32:** Any state-required benefits enacted prior to 12/31/11 are considered EHB (45 CFR 155.170). QHP benefits and limits must be substantially equal to benchmark benefits and limits. See the final rule on EHB for additional explanation, available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Health Benefits (EHB)	**Q33:** The AV Calculator only has a field for "Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services" and doesn't split out the office visit services from the outpatient services. As a result, we don't know if we need to fill out that field with parity to outpatient or parity to office visits. Our plan was to put in similar cost sharing for that	**A33:** We developed the AV Calculator for the purpose of calculating AV with a limited number of service inputs, and it was not specifically designed to demonstrate parity. Therefore, for the purposes of calculating AV, we recommend that you use your best actuarial determination to align these benefits to the AV Calculator, as described in the AV calculator methodology incorporated by reference into the Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule. We further recommend taking the higher cost-sharing rate where possible. Per your example, we agree that you should provide any additional information in your EOC. We also note that, under the	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	benefit as medical outpatient and to explain in our Explanation of Coverage that behavioral health office visits would receive PCP cost sharing.	mental health parity requirements applicable to coverage of the essential health benefit category of mental health and substance use disorder services, including behavioral health treatment, outpatient services and office visit services are considered to be within the same classification (see 45 C.F.R. § 146.136(c)(2)(ii)).			
Plan Management Webinar: Essential Health Benefits (EHB)	**Q34:** How can a State identify the issuers that have reported that they intend to offer stand-alone dental plans in the Exchange?	**A34:** At http://cciio.cms.gov/resources/files/voluntary-dental-reporting-list-1-28-13.pdf, we explained how dental issuers voluntarily reported their intent to offer stand-alone dental coverage and we provided a list of states and how many issuers in each state intend to offer stand-alone coverage.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Rating	**Q17:** When will the rate review template be published?	**A17:** The Unified Rate Review template was published in the Federal Register on February 27, 2013 at 78 FR 13406. The publication of this template contains all the data elements that issuers are required to submit.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Rating	**Q50:** For issuers with filing only new products as QHPs, is it correct that they do not need a Unified Rate Review (URR) Template as part of their QHP submission, given that the URR	**A50:** No. Any time that the URR Template is filled out, all plans in the risk pool -- even those not being submitted for QHP certification -- have to be included. Since the Index Rate can be set only once per year for the whole risk pool, that also means that all plans in the risk pool have to have their rates approved at the same time, both on and off the Exchange, as required by a	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	Template is only for rate increases?	combination of Exchange (77 FR 18310) and Rate Review rules (78 FR 13406) . This is true even if all of the plans are new.			
Plan Management Webinar: Rating	**Q51:** There appear to be errors in the validation macro in the rate template. When the macro is trying to check for proper relationship between rates for different age brackets and tobacco vs. non-tobacco rates, it produces erroneous results. If the Tobacco field is listed with "No Preference" and changes to "Tobacco User / Non-Tobacco User" after the Age is selected, the Individual Tobacco Rate column will not show.	**A51:** The macros in the Rate Table Template are written such that the tobacco use column is hidden (not deleted) when "no preference" is input for tobacco use. If issuers find this confusing, they can generate additional sheets and use separate sheets for plans which use tobacco rating and those that do not. If a plan has some age bands which use tobacco rating and some which do not, the issuer should not mark the age bands as no preference, but should instead enter the same rate in both the tobacco use and non-tobacco use columns for those age bands which do not differentiate. This will avoid the display issue.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Rating	**Q52:** The calculation of 3:1 ratio on non-tobacco rates is not correct. The validation macro marks some of the cells as in violation	**A52:** Due to a system limitation in the Rating Tables Template, the system currently cannot process a premium for a 65-year-old smoker that is rated more than 3 times the premium of a 21-year-old smoker. We ask that all issuers submitting rates via the Rating Tables	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	of 3:1, which is not the case. Per the Market Reform Final Rules at 45 CFR 147.102(a)(1)(iii), “such rate may not vary by more than 3:1 for adults." In an example provided by CMS Plan Management Support, sample data was used to demonstrate that the age 21 individual rate must be multiplied by 3 to derive the maximum age 65 individual rate. However, in order to check for an allowed ratio of 3:1, you need to take the age 65 rate and divide by the age 21 rate and see if that ratio equals to 3:1. The problem with the validation method cited by CMS and included in the template macros is that it uses the wrong operation when checking for 3:1	Template for non-grandfathered plans in the individual and small group markets implement the tobacco rating factor so that older adult smokers are not rated in total more than 3 times of the total rate for a younger adult smoker. One way to accomplish this is if an issuer imposes a 1.2 to 1 tobacco rating factor on a 21-year -old smoker, the issuer should use the same 1.2 tobacco rating factor for the 65-year-old smoker. If an issuer implements the tobacco rating factor with the result that an older smoker is rated up more than 3 times of that of a younger smoker, the submission of the issuer will be rejected by the system. We intend to implement a system change that will allow for processing of tobacco rating factors that vary based on age, and we expect this to be completed after calendar year 2014.			

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	compliance. The small differences resulting from using this incorrect operation for validation will result in a huge problem for issuer billing systems.				
Plan Management Webinar: Rating	**Q53:** The template allows entry of a Rating Area ID and allows up to 150 Rating Areas to be selected. It is unclear how these rating areas will be mapped to the appropriate area within each state (or service area) to identify the appropriate rating. How will the Exchange know the proper premium based on a member's address? How will rating areas be consistent across multiple QHP issuer submissions within each state?	**A53:** Each individual state is setting its own rating areas and providing the specific areas within a state that associate to each rating area. The Rate Table Template collects the rates for each rating area in the state. Issuers should use those state-provided rating areas to complete the Rating Area ID piece of the template. The rating areas for each state are published on the CCIIO website http://cciio.cms.gov/programs/marketreforms/state-gra.html.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Rating	**Q54:** When tabbing out of the Age field,	**A54:** For states that do not have community rating, the template	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	the debugging macro pop-up was generated.	automatically creates rows for all age bands when a single age band is selected. The age bands once created may not be edited. If you continue to have this issue, please contact the Help Desk.			
Plan Management Webinar: Rating	**Q55:** Please clarify whether area rating can vary by network.	**A55:** If an issuer offers two QHPs with the same benefit package and cost-sharing, but with two different networks (for example, a broad network vs. a narrow network), the issuer may make a plan-level adjustment to its market index rate to reflect the expected cost differences resulting from network difference between those two QHPs. The state may place additional restrictions on rating flexibility in the state, and all QHPs offered on the Exchange must comply with state law and be approved by the state.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Rating	**Q56:** After entering Age in the appropriate field, upon keying cursor up, Age decrements and is placed in incorrect row on spreadsheet.	**A56:** Rates must be submitted for all age bands. The age bands will populate in order regardless of the age that you select.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Rating	**Q57:** The Tobacco Rate column does not appear until Age Bracket is selected, instead of upon selection of value in	**A57:** This is by design. The template requires both the tobacco option and the family/age band option to be selected before displaying the appropriate columns for the rates.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	the Tobacco drop-down.				
Plan Management Webinar: Rating	**Q22:** For the individual market, will the area rating be applied at the subscriber level?	**A22:** The rating will be based on the subscriber address.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: Rating	**Q28:** When will the rate review template be published?	**A28:** The Unified Rate Review (URR) template was published in the Federal Register on February 27, 2013 at 78 FR 13406. The HIOS enabled version is available within the Unified Rate Review Module of the Plan Management and Market Wide Functions section of HIOS, along with downloadable URR Template Instructions and the Actuarial Memorandum Instructions.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q29:** Do non-Exchange plans have to be submitted for rate review at the same time as QHPs?	**A29:** Yes, any time that the URR template is completed, all plans in the risk pool, even those not being submitted for QHP have to be included. Since the Index Rate can be set only once per year for the whole risk pool, that also means that all plans in the risk pool have to have their rates approved at the same time, both on and off the Exchange.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q30:** Does the URR template have to be submitted in HIOS for a partnership State?	**A30:** Yes, any time that the URR template is submitted to a State, it must also be submitted to CMS via HIOS. Alternatively, any time the URR template is submitted to CMS in HIOS, it must be submitted to the State. This	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		includes modifications or changes required by either government entity.			
Plan Management Webinar: Rating	**Q31:** Will a "user guide" be provided for the URR Template?	**A31:** Yes, one is currently available in the URR Module of HIOS.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q32:** Because network design and structure is an allowable modifier to the Index Rate, can an issuer sell two plans with identical benefit and cost-sharing designs where the only difference is the network type?	**A32:** Yes, if there is a meaningful difference in the networks of the two plans, they can be identical in other ways and still be considered two different QHPs. Please see the 2014 Letter to Issuers for further information on meaningful difference in Chapter 1, Section 4.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q33:** If a State with a State Partnership Exchange has a different submission deadline, when is the URR template required to be submitted to HIOS?	**A33:** The submission to CMS in HIOS should be at the same time as the submission to the state.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q34:** Does the Part III Actuarial Memorandum have to be submitted every time the Part I, Unified Rate Review Template is submitted?	**A34:** Yes, the Part III Actuarial Memorandum is now required with every initial Part I URR template submission. The Part II Consumer Justification Narrative is only required when at least 1 product in the risk pool is experiencing a rate increase of 10% or more.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Plan Management Webinar: Rating	**Q35:** What the difference between the Unified Rate Review system and the Rate Review Justification system?	**A35:** The Unified Rate Review (URR) Module, within the Plan Management & Market-Wide Functions section of HIOS is the module used to submit all rate filings required after 4/1/2013. The Rate Review Justification (RRJ) Module is the legacy system which was used to submit rate filing justifications prior to 4/1/2013. The RRJ Module continues to be used to provide rate reasonableness determinations and justifications until all submission made prior to 4/1/2013 have received determinations.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q36:** For rate review, how is a "new" product defined?	**A36:** 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.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q37:** Are all non-grandfathered business renewing in 2014 new, and therefore would it not need to be submitted in HIOS?	**A37:** The FFE application requirements include submitting the entire risk pool using the URR module and templates, if even one plan in the risk pool is included in the QHP application.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q38:** If an issuer is modifying existing non-ACA compliant plans to be ACA compliant for 2014, how is the rate increase determined?	**A38:** Rate increases take into account all reasons for the rate change, including State mandated benefits or compliance with EHB standards.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Plan Management Webinar: Rating	**Q39:** Will there be instructions released for the URR template and Actuarial Memorandum?	**A39:** Yes, they are published in the URR Module within HIOS.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q40:** Are there different rate review templates for new rates versus rate increases?	**A40:** No, the same template is used for all new and existing plan rates. The instructions provide an explanation of how to handle discontinuing plans rate experience, continuing plans experience and projections, and new plan projections.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q41:** If an issuer wants to include grandfathered experience in its projections, how is this done?	**A41:** The URR template instructions provide further guidance on this, but grandfathered experience, if included, should be included in the Credibility Manual Adjustment within worksheet 1.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q42:** If we plan to modify all grandfathered health plans such that it will lose grandfathered status, should we include the experience of those grandfathered health plans in the experience period?	**A42:** Yes, if you are modifying the entire grandfathered health plan such that it will no longer be considered a grandfathered health plan, the experience should be included in the experience period data on the URR template.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q43:** If an issuer changes rates by less than 10% in 2013, does it have to submit them in the	**A43:** Yes, all rate changes submitted after April 1st, 2013 must be submitted on the URR template, and when submitted, the entire risk pool must be included.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	new URR template after April 1, 2013?				
Plan Management Webinar: Rating	**Q44:** Will the entire QHP application be rejected if rates are found to be unreasonable?	**A44:** If unreasonable rate determinations are made, the Exchanges are required to take that information into account within their determination, but an automatic rejection is not required by rule or law. See Chapter 1, Section 3 of the Issuer Letter for more information on review of rates. If an issuer's rates are declared "unreasonable" the State or HHS will generally provide the issuer a window to make corrections.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q45:** If a State has an Effective Rate Review program and an issuer has no QHPs, does the issuer still have to submit the URR template to CMS?	**A45:** If an issuer has a rate increase on any plan after April 1, 2013, it is required to submit the increase and the entire risk pool to both their state and CMS pursuant to 45 CFR 154.200.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q46:** Is the index rate meant to be representative of specific plan richness, e.g., 60% actuarial value (AV)? Similar to AV, is the index rate meant to be the 21 year old rate in an area that has a factor of 1.0 so that all other rating factors can be	**A46:** No. The index rate is an average rate based on the total combined claims experience derived from providing EHB to enrollees in all non-grandfathered health plans in a market. The index rate is utilized to set the base rate for all of an issuer's products in a market. The index rate may be adjusted at the plan level to reflect a plan's actuarial value and cost-sharing design; provider network; benefits in addition to EHB; administrative costs; and with respect to catastrophic plans, the specific	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	applied to it?	eligibility categories of the plan. The premium rate for a given individual may further vary based on the premium rating factors in section 2701 of the PHS Act.			
Plan Management Webinar: Rating	**Q47:** When deriving an index rate, what normalization factors are permitted?	**A47:** The market reform final rule, published on February 27, 2013 at 78 FR 13406, does not allow for normalization, since the index rate must use the issuers' EHB claims experience in the market. The only plan-specific adjustments to the market-wide index rate are those described above.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q48:** The final market reform rule says that the index rate cannot be adjusted for induced demand. Is this intended at the plan level, market level, or both? If not allowed at the plan level, would that mean that induced demand could be socialized across all plans based on an assumed distribution?	**A48:** As stated in the market reform final rule, 78 FR 13406, we exclude an induced demand factor from the plan-specific rate adjustments because of the actuarial difficulty of measuring whether differences in total plan expenditures are due to risk selection or induced demand. However, for the purpose of developing an adjustment to the market-wide index rate for individual plans based on the plan's actuarial value, issuers would use pooled allowable claims data as a basis for calculating the plan-specific actuarial value.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Rating	**Q58:** Will a subscriber be locked into his/her smoker status/rate region for	**A58:** If a subscriber's smoking status changes from smoker to non-smoker mid-year (or in the small group market, the subscriber agrees to participate in a	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	a full contract year, or can these items change mid-year and change the premium rate mid-year as a result?	tobacco cessation program pursuant to PHS Act section 2705(f)), any tobacco surcharge should be immediately be prospectively removed from the premium.			
Plan Management Webinar: Rating	**Q59:** Can a family plan cover family members who reside in different rating areas of the same State?	**A59:** Yes, issuers can cover family members who live in different rating areas under the same plan. For the individual market family plan, all family members can be rated at the location of the subscriber, even if a family member is residing in a different rating area than the subscriber.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Rating	**Q60:** In the individual market, if an enrollee permanently moves to a new geographic rating area mid-year, is he/she required to switch to a plan in the new rating area, or can he/she keep their other plan until the next renewal?	**A60:** Whether or not an individual can remain on a plan depends on whether the individual still lives or resides within the service area of the plan upon moving to the new location.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Rating	**Q61:** If the enrollee does re-enroll, per the previous question, are the rates based on age and tobacco use at the new enrollment date?	**A61:** If the individual enrolls in a new plan, age and tobacco use would be determined at time of enrollment.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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Plan Management Webinar: Rating	**Q62:** Does validation compare the age 65 rate to the age 0-20 rate, or compare the age 65 rate to the age 21 rate? Is this because the age 65 rate cannot be more than 3x the age 21 rate?	**A62:** The 3 to 1 age ratio factor requires that the 64+ age band be no more than 3 times the rate of a 21 year old who would be rated at 1.0. Validation is being done against the age 21 category. This validation is being done across non-smoking rates, and is also being applied between rates for smokers. Early versions of the template may have been built with incorrect references, but these have been corrected. The current rate table template version is 1.6.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q18:** Can you please clarify what is an "Essential Community Provider"? Please provide a full definition and parameters for states that may not have all ECP's due to population size, geographic barriers, or provider types that do not exist specific to the state.	**A18:** As defined in section 1311(c)(1)(C) of the Affordable Care Act and in 45 C.F.R. 156.235(c), ECPs are providers that serve predominantly low-income, medically underserved individuals, including providers described in section 340B(a)(4) of the PHS Act, and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. Please note that ECP inclusion will be evaluated based upon the extent to which ECPs are available in the service area of the issuer.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q19:** Is the evaluation of ECPs at a county or service area level?	**A19:** The percentage thresholds will be calculated based upon the issuer's service area. See 45 CFR §156.235 and the Letter to Issuers on Federally-facilitated and State Partnership Exchanges. To qualify for the safe harbor articulated in the issuer letter	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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		starting on page 7, the issuer will be expected to have contracts with at least 20 percent of the available ECPs in the proposed service area (published on the CCIIO website on April 5, 2013, at: http://cciio.cms.gov/resources/regulations/Files/2014_Letter_to_Issuers_04052013.pdf). To meet the safe harbor, please note that the issuer would also need to offer contracts to all Indian providers in the service area, and offer contracts to at least one ECP in each ECP category in each county of the service area, as noted in the letter.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q20:** If a service area is statewide, does the safe harbor standard mean that the issuer can contract with 20 percent of the ECPs in the state overall and meet the requirements?	**A20:** If the issuer's service area is statewide, then the issuer would need to contract with at least 20 percent of the ECPs in the State to quality for the safe harbor. The issuer would also need to meet the standard set forth in the issuer letter and noted above, in question 20, regarding Indian providers and offering contracts to at least one ECP in each ECP category.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q21:** How will the requirement to offer contracts to at least one ECP per category apply if there are no ECPs in the category in the service area?	**A21:** As a condition of the safe harbor, issuers will need to offer contracts to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available. Please be sure to check the non-exhaustive listing of ECPs to determine the availability of ECPs in the service area. This list was published 3/26/13. Information on the list and a link to the	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf

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		list can be found at http://cciio.cms.gov/programs/exchanges/qhp.html .			
Plan Management Webinar: Essential Community Providers (ECP)	**Q22:** If there are not any available Indian Health Service (IHS) providers in the state per the IHS website, do the ECP requirements still apply?	**A22:** Indian providers also include tribal and urban Indian organizations. Please check the non-exhaustive list of ECPs referenced previously to verify whether any Indian providers are available in the proposed service area.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q23:** If the network adequacy standard for ECP cannot be met, issuers can submit a satisfactory narrative justification. What elements would make the response satisfactory as opposed to unsatisfactory?	**A23:** HHS expects that an issuer that does not achieve the safe harbor standard submit a narrative justification using the ECP Supplemental Response Form. The QHP Application identifies the specific elements that must be addressed in the narrative justification in the ECP Supplemental Response Form. This would include providing information on why the issuer was not able to achieve the safe harbor standard, how the issuer plans to increase ECP participation, and how the existing network would provide access for low-income and medically underserved populations. Issuers will need to respond to each specific element requested in the ECP Supplemental Response Form, as applicable.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q15:** Regarding the ECP template, if an ECP has multiple addresses should we	**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,	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	list the ECP twice, once with each address?	e.g. Provider – 001.			
Plan Management Webinar: Essential Community Providers (ECP)	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q28:** The Essential Community Provider (ECP) Template includes a column for Provider Name. Is an issuer required to enter each ECP by name or can the issuer enter the ECP entity name when applicable, knowing that an ECP entity may include multiple providers?	**A28:** Please enter the name of the ECP entity for each location of the ECP entity, even if the ECP entity has multiple providers at a specific location.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Essential	**Q29:** If we subcontract our	**A29:** If the issuer subcontracts with another entity for psychiatric services	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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Community Providers (ECP)	psychiatric work, how do we represent that on the ECP template?	and the entity in turn contracts with an ECP, the ECP should be included in the issuer's ECP template if listed in the provider directory for the issuer's QHP.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q30:** If an Indian health provider does not contract with an issuer, can the issuer treat it as a non-participating provider?	**A30:** Even if an issuer does not have a contract with an Indian health provider, and the Indian health provider provides services to an Indian who is a member of the issuer's QHP, the Indian health provider would have a right of recovery authorized under section 206 of the Indian Health Care Improvement Act (25 U.S.C. §1621e). Section 206(a) and (i) of the Indian Health Care Improvement Act provide that the Indian Health Service, an Indian tribe, tribal organization, and urban Indian organization have a right to recover reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. However, HHS notes that if an issuer and Indian health provider sign a QHP agreement that uses the model QHP Addendum for Indian health providers and the issuer and Indian health provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of Indian Health Care Improvement Act.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Essential Community Providers	**Q31:** How should an issuer handle out-of-state Indian	**A31:** To the extent that an out-of-state Indian health provider is not a part of an issuer's network, the issuer could	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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(ECP)	providers; should they be treated as in network or out-of-network?	consider the Indian health provider as an out-of-network provider. However, the Indian health provider's right of recovery afforded under section 206 of the Indian Health Care Improvement Act referenced in the response to the question "If an Indian health provider does not contract with an issuer, can the issuer treat it as a non-participating provider?" (above) would apply. HHS notes that issuers may want to consider contracting with Indian health providers in neighboring states, as tribal lands often cross state borders.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q34:** It is unclear in the QHP Application instructions how to list an Essential Community Provider more than once for multiple locations. What convention should issuers use in the ECP Template?	**A34:** Three digits should be added at the end of the Provider Name (i.e., Provider Name-003).	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q35:** In the ECP template, should issuers include in the ECP providers that are currently not contracted but with which the issuer intends to contract prior to September 2013?	**A35:** The issuer should only enter ECPs with which it currently has contracts in the ECP template for purposes of meeting the safe harbor standard. In the justification, the issuer should list any additional ECPs with which it is in the process of contracting.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
(HHS/CCIIO; Labor; Treasury/IRS)

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Plan Management Webinar: Essential Community Providers (ECP)	**Q36:** If the issuer is reaching out to ECPs in its region to see if they would be interested in participating in the issuer's network, where and how does the issuer document this action of good intent in its QHP Application?	**A36:** The applicant can document these efforts in the narrative justification.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q37:** If the ECP address is incorrect on the official HHS ECP list, can the issuer enter the correct address in the ECP template or does the template need to match the HHS List?	**A37:** The applicant should enter the correct address information into the ECP Template.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q38:** There are ECPs in the CMS non-exhaustive list that are closed that prevent the issuer from offering a contract to at least one ECP in each county where plans will be offered. How should the applicant indicate this	**A38:** In order to meet the safe harbor standard, the applicant would need to indicate by submitting the ECP Template that at least 20% of available ECPs in the plan's service area participate in the issuer's provider network. In addition, the issuer must offer contracts prior to the coverage year to: 1) All available Indian providers in the service area, and 2) At least one ECP in each category in each county in the service area, where an	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	information to CMS?	ECP in that category is available. If there is no single ECP in a given category in a given county and service area, the issuer should note this in its justification. The ECP list is not exhaustive, and does not include every provider that may qualify as an ECP. Issuers that are clearly unable to meet the regulatory standard, including the 20% safe harbor standard, because of limitations of the list (such as a provider that is no longer in business) may provide a justification using the ECP Supplemental Response Form, which can be found at http://cciio.cms.gov/programs/exchanges/qhp.html. Please note the issuer also has the ability to write in additional ECPs in the ECP Template. More information on the ECP standards can be found in Chapter 1 of the 2014 Issuer Letter, available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf			
	Q49: Where can the "ECP Supplemental Response form" be found?	**A49:** You may download the form at http://cciio.cms.gov/programs/exchanges/qhp.html under QHP Application Materials, specifically at http://cciio.cms.gov/programs/Files/ecp_supplemental_response_Form_03_08_13.pdf.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential	**Q50:** For ECPs that are facilities, can	**A50:** Please list the location of each facility.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Community Providers (ECP)	issuers list both the facility and the provider in the ECP template?				
Plan Management Webinar: Essential Community Providers (ECP)	**Q51**: If an Indian Health Provider refuses to contract with an issuer, can the issuer treat them as a non-participating provider?	**A51:** Even if an issuer does not have a contract with an Indian health provider, and the Indian health provider provides services to an Indian who is a member of the issuer's QHP, the Indian health provider would have a right of recovery authorized under section 206 of the Indian Health Care Improvement Act (25 U.S.C. §1621e). Section 206(a) and (i) of the Indian Health Care Improvement Act provide that the Indian Health Service, an Indian tribe, tribal organization, and urban Indian organization have a right to recover reasonable charges billed, or, if higher, the highest amount an insurance carrier would pay to other providers. The issuer could not balance bill. However, we note that if an issuer and Indian health provider sign a QHP agreement that uses the model QHP Addendum for Indian health providers and the issuer and Indian health provider mutually agree to rates or amounts specified in the QHP agreement as payment in full, the QHP issuer is deemed to be compliant with Section 206 of Indian Health Care Improvement Act.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential	**Q52:** How should an issuer treat out-of-	**A52:** Even if the Indian provider is out-of-state, the Indian health provider's	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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Community Providers (ECP)	state Indian Health Providers?	right of recovery afforded under section 206 of the Indian Health Care Improvement Act references in the response to the previous question would apply. We note that issuers may want to consider contracting with Indian health providers in neighboring states, as tribal lands often cross state borders.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q53:** If an Indian Health Provider is contracted, does an issuer treat that provider as an Indian Health Provider or does that mean they are treated as a network provider (i.e., can the issuer balance bill)? Are referrals from Indian Health Providers to a non-Indian Health Provider for AI/AN individuals who make over 300% FPL included in the 100% cost share or treated as normal contract rates?	**A53:** *If a QHP issuer contracts with an Indian Health provider, the QHP issuer may pay the Indian Health provider at the negotiated rate when using the QHP Addendum for Indian providers, even if it is a lower rate than the reasonable billed charged. If the QHP issuer does not contract with an Indian Health provider, the QHP issuer must reimburse the provider as required by section 206 of the Indian Health Care Improvement Act. This policy applies regardless of whether or not the enrollee has a household income greater than 300% of the Federal Poverty Level (FPL) and is eligible for the limited cost sharing plan variation. *Edited on 4/26/13	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q54:** On the ECP template, please clarify what "Ancillary" and "Other" refer to.	**A54:** Only issuers that qualify for the alternate ECP standard outlined in Chapter 1 of the Issuer Letter should list locations of ancillary providers in HPSA or low-income zip codes. Ancillary	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		providers that are those not providing primary care, specialty care, inpatient or outpatient hospital services, or pharmacy. For issuers that do not qualify for the alternate ECP standard, please see the description of the "Other ECP Category" contained in the Issuer Letter.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q55:** In the HRSA 340B database, ECPs may have multiple NPI numbers based on their organizational structure. Will HHS be matching on all NPIs an entity has or a specific NPI that an entity has?	**A55:** As noted in Chapter 7 of the QHP application instructions, NPI is an optional field in the ECP template for this year. We are not matching on NPI this year, but are gathering data on available NPIs. If multiple NPIs exist for a given ECP, please use the NPI that mostly closely matches the specific location or department for the provider listed in the ECP database, if possible.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q56:** When would an issuer enter NA in the ECP template?	**A56:** Please see Chapter 7 of the QHP application instructions. If the alternate ECP standard applies to the issuer, please complete the Provider Type column and mark "NA" in the ECP Category column. If the alternate ECP standard does not apply to the issuer, please complete the ECP Category column and mark "NA" in the Provider Type column.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q57:** Both the ECP and Network templates generate Network IDs. Do those both refer to	**A57:** When entering Network IDs, you must assign networks the same numbers as those assigned in the Network ID and Benefit templates. Please see Chapter 7 of the QHP application instructions.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	the same network? Do the network names need to be consistent?				
Plan Management Webinar: Essential Community Providers (ECP)	**Q58:** What if an ECP provider type does not exist in our State in some regions?	**A58:** As specified in 45 CFR 156.235(a), a QHP issuer must have a sufficient number of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area. If there are no ECPs that belong to a particular ECP category in the service area of the issuer, the issuer should indicate this in the justification. However, if there are ECPs in a particular ECP category in some regions of service area, the issuer would still be expected to offer contracts to those ECPs as part of the safe harbor standard.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q59:** If an issuer contracts with some of the providers that work at an ECP listed on the non-exhaustive ECP database, but not with the ECP itself, can the issuer include the ECP on its ECP template?	**A59:** No. If the issuer contracts with providers that work for an ECP listed on the non-exhaustive ECP database, but not with the ECP entity itself, the issuer cannot include the ECP on the issuer's ECP template. However, if the issuer does not meet either the 10% or 20% thresholds, the issuer may list or describe its contracts with individual providers that work for the ECP as part of its justification.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Essential Community Providers	**Q18:** In contracting with an Essential Community Provider	**A18:** The issuer would need to contract with the ECP as listed in the HHS non-exhaustive list of ECPs. The list is	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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(ECP)	(ECP), can an issuer contract with a doctor in the practice or does the issuer need to contract with the listed practice?	available at http://cciio.cms.gov/programs/exchanges/qhp.html.			
Plan Management Webinar: Essential Community Providers (ECP)	**Q19:** Where can issuers find the Model Indian Addendum referenced in the ECP Template instructions?	**A19:** The Model Indian Addendum can be found on the CCIIO website at http://cciio.cms.gov/programs/Files/Model_QHP_Addendum_04_04_13.pdf.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q20:** Is the Model Indian Addendum document required to be submitted with the QHP Application?	**A20:** This addendum does not need to be submitted to HHS with the QHP application.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Essential Community Providers (ECP)	**Q21:** If a company is made up of multiple Physician Hospital Organizations, does it qualify for the alternate standard for ECPs?	**A21:** As referenced in the Letter to Issuers, in order to be considered as meeting the alternate standard, the issuer must meet the requirements laid out in 45 CFR 156.235(a)(2) and (b): 45 CFR 156.235(a)(2) states that a QHP issuer that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section. 45 CFR 156.235(b) states that Alternate standard. A QHP issuer described in paragraph (a)(2) of this section must	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.			
Plan Management Webinar: Templates	**Q24:** Please provide the XML standards for the templates – are they different for each template?	**A24:** Yes, they are different for each template. The template itself will generate the .xml file.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Templates	**Q25**: Are the Individual (FFE) and SHOP (FF-SHOP) templates similar or exactly the same?	**A25:** There is a single template for FFE and FF-SHOP submissions. You will be required to submit your Individual Plans and Benefits separately from your SHOP plans and benefits, but both use the same template. The template validation will apply the market (FFE or FF-SHOP) dependent business rules.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Templates	**Q26:** When is the rate review template due and will this be concurrently with the rest of the templates at the end of April?	**A26:** If an issuer has at least 1 QHP Application, April 30 is the deadline. If the issuer is not submitting any QHPs, then they must follow State rules or submit before January 1, 2014.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: Templates	**Q24:** Is the section "Disease management programs" displayed on the SBC and/or	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	plan compare?	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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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).	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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		Section at 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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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		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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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 are consisting of those all three areas combined, and use that single ID for completing the Benefits Template.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**Q32:** Will upcoming drafts of templates indicate which fields	**A32:** The Data Traceability Matrix (DTM) is currently available through the NAIC website	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	are required for the QHP application?	(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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**Q35:** Will the data templates from the initial application in April 2013 be used on an ongoing basis,	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	such as when filling new products with the state?	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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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		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.			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management	**Q39:** What is the	**A39:** The "Add Benefit" button in the	FAQ April 9,	CMS	https://www.regtap.info/uploads/library/

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Webinar: Templates	"Add Benefit" button intended to do?	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.	2013		QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**Q42:** How do issuers answer column P, "Indian Plan	**A42:** If applicable, issuers should enter a dollar amount in this optional field. Estimated amount of cost-sharing	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	variation - Est advanced payment," for products without an Indian variation?	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).			
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**Q45:** Can HHS make public the EHB Crosswalk that is mentioned in the	**A45:** HHS has made available a tool called "the USP Category Class Count Service" (the Counting Service) to enable issuers and States to submit	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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	recently published Methodology document?	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.			
Plan Management Webinar: 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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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Plan Management Webinar: Templates	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Templates	**Q32:** What is the purpose of the field "Unique Plan Design" in the benefits template?	**A32:** As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, issuers must indicate if the health insurance plan has a unique design, for purposes of the AV Calculator. This is a 'Yes' or 'No' field, and issuers will be asked to indicate whether the plan design is unique, meaning it cannot use the standard AV Calculator. If the plan design is unique for purposes of calculating AV, upload the Unique Plan Design Supporting Documentation and Justification (See Chapter 13: Unique Plan Design Supporting Documentation and Justification for a suggested format.). The actuarial certification is a signed and dated certification indicating that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable Federal and State laws and actuarial standards of practice. An example of plan designs that could be considered "unique" for purposes of determining AV would be a plan with coinsurance rates that increase with out-of-pocket spending, such as a plan design with 10	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		percent coinsurance for the first $1,000 in consumer spending after the deductible, 20 percent coinsurance for the next $1,000 in consumer spending, and 40 percent coinsurance up to a $6,400 out-of-pocket maximum. This plan design would be considered "unique" because the current AV Calculator can only accommodate a single coinsurance rate for each benefit.			
Plan Management Webinar: Templates	**Q33:** How should the benefits template be completed if infertility is not covered?	**A33:** As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, if a benefit is not covered, select "Not Covered" in the "Is this Benefit Covered" field of the Plan & Benefits template. If this field is changed to 'Not Covered' for an EHB then you must substitute another benefit or combination of benefits in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification (Instructions Chapter 13B) to support the actuarial equivalence of the substitution.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q34:** What should be entered in fields starting with "Primary Care Visit to Treat an Injury or Illness," when a plan has a copay or coinsurance, but not both??	**A34:** Please refer to the "Covered Benefits" section of Chapter 10: Instructions for the Plans & Benefits Application Section for information to complete the copayment and coinsurance fields of the Plans & Benefits Template. For example, under "Copay–In Network	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		(Tier 1)," if an in-network copayment is charged, enter the dollar amount. If no copayment is charged, enter No Charge. Choose from the following: a. No b. No Charge after deductible c. $X Copay d. $X Copay after deductible e. $X Copay before deductible. Under "Coinsurance–In Network (Tier 1)," if an in-network coinsurance is charged, enter the percentage. If no coinsurance is charged, enter "No Charge," unless your plan has a tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter "0%." Choose from the following: a. No Charge b. No Charge after deductible c. X% Coinsurance after deductible d. X%.			
Plan Management Webinar: Templates	**Q35:** What are the "Plan Data Elements" identified in appendix B1 needed for?	**A35:** Plan-level data elements are used to identify high-level data about each plan, including its ID and which network, service area, and formulary the plan will be using. Plan-level	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		information applies to each standard plan you want to create for this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage, and a benefits package is a group of plans that cover the same set of benefits; each plan in a benefits package can have different cost sharing, which is defined in the Cost Share Variances tab.			
Plan Management Webinar: Templates	**Q36:** In the Benefits template what do utilization, cost share, and projected utilization rates mean?	**A36:** When the user is using Multiple In-Network Tiers, the Plans and Benefits Template requires that the user input the service utilization rates in each of those tiers that are equal to 100%. This information is used in the calculation of AV. If the user does not have multiple in-network tiers and selects "no" under column "I" (Multiple In-Network Tiers), the Plans and Benefits Template grays out the second tier of utilization and the user should input the "100%" under the first tier.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q37:** How should the Drug Tier IDs be defined?	**A37:** The Drug Tier ID is a required field in the Prescription Drug template (see Chapter 12: Instructions for the Prescription Drug Application Section). This template populates the number of tiers according to your selection in Number of Tiers. Issuers may refer to the “Suggested Coordination of Drug Data Between Templates” in Chapter 10: Instructions for the Plans & Benefits Application Section for additional	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		information related to tier and deductible data for drug and medical benefits.			
Plan Management Webinar: Templates	**Q38:** What does the field "CSR variation type" mean?	**A38:** The "CSR Variation Type" refers to Cost Sharing Reduction information that must be submitted at the plan and benefit cost sharing levels. This field auto populates with the following based on cost sharing data entered into the template: Standard Silver Off Exchange Plan, Standard Silver On Exchange Plan, Zero Cost Sharing Plan Variation, Limited Cost Sharing Plan Variation, 73% AV Level Silver Plan, 87% AV Level Silver Plan and 94% AV Level Silver Plan.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q39:** What fields will be pre-populated with the Benchmark Plan data?	**A39:** As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, the following fields may auto-populate in the Plan & Benefits Template: EHB, State Mandate, Is this Benefit Covered?, Quantitative Limit on Service, Limit Quantity, Limit Unit, Minimum Stay and Explanation.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q40:** For State-based Exchanges, will issuers receive pre-populated templates?	**A40:** HHS has made the add-in file with benchmark information available to all States. In a State-based Exchange, please defer to the State for guidance on the specific data collection instrument that will be used.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q41:** Are coverage level and metal level the same?	**A41:** As noted Chapter 10: Instructions for the Plans & Benefits Application Section, the terms coverage level and	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		metal level are used interchangeably throughout the templates and QHP Application.			
Plan Management Webinar: Templates	**Q42:** How do issuers incorporate riders?	**A42:** The FFE and State Partnership Exchange templates will not collect or display optional riders. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the FFM, an issuer should submit two plans, one with and one without the rider. Depending upon the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFM website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q43:** How do issuers enter coinsurance values in the Plans & Benefits template and the AV Calculator?	**A43:** While the coinsurance values in the Plans & Benefits template represent the percentage of costs that the enrollee pays for a given service, the coinsurance values in the AV Calculator represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AV Calculator must be set equal to 1-X%, where X% is the coinsurance value entered in the Plans & Benefits template. For example, if enrollees pay 10 percent of Specialist Visit costs, the coinsurance in the Plans & Benefits template would be equal to 10 percent. The coinsurance in the AV Calculator would be equal to 90 percent to represent the 90 percent of costs	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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		incurred by the issuer.			
Plan Management Webinar: Templates	**Q44:** There have been a variety of technical problems with the benefits template. How can issuers move forward with using this template?	**A44:** Issuers may have technical issues when the Plans and Benefits Template Add-in file is not installed. To fix this: 1. Delete all versions of the add-in file. 2. Download the current version of the add-in file. Make sure you select "Save" from the dialog box, not "Open." 3. Open the Plans and Benefits Template. You should see a "Plans and Benefits v.X.XX"on the features bar. 4. Enable Macros. 5. See the user guide and instructions for troubleshooting help. 6. Call the helpdesk if the previous suggestions do not solve the technical problem.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Templates	**Q1:** Can issuers copy and paste data into the templates?	**A1:** All the templates allow for the copying and pasting of data. See "Copying and Pasting in Plan Management Templates" at https://zone.cms.gov/document/copying-and-pasting-plan-management-templates.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q2:** Why is the file not automatically defaulting to be saved in .xml format?	**A2:** Depending on your Microsoft Office settings, when you click "Finalize" and are prompted to enter a document name, Excel will automatically populate the field with the	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		current file format, which is ".xls" or ".xlsm." Simply delete this and enter your desired file name. You do not have to add ".xml" at the end, just the file name.			
Plan Management Webinar: Templates	**Q3:** How do the Service Area ID, Network ID, and Formulary ID relate to the Plans and Benefits Template?	**A3:** The Plans and Benefits Template includes macros that allow users to import their IDs from other templates into the Plans and Benefits Template. Macros create the IDs required for all medical plans, with the exception of the Stand-alone dental plans, which do not require a Formulary ID. For each plan, there can only be a single instance of the ID. The Service Area ID must include the entire service area for the plan. The Network ID must include the link that consumers will use to get information about the all the covered providers under the plan. The Formulary ID must include the link that consumers will use to get information about the formulary.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q4:** Why do issuers see errors displayed when clicking "validate"?	**A4:** The message box with the validation errors allows issuers to see what needs to be corrected. The template can be validated multiple times, and clicking the "Finalize" button will perform those validations again. If there are any errors that were not corrected, the error messages will display again.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q5:** Do the templates have to be submitted in a special order?	**A5:** The templates can be submitted in any order, as long as they are submitted by the deadline. There is no dependency	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		that one be entered before another. However, in the Plans and Benefits Template, it is easier to have the IDs for the Network, Formulary, and Service Area prior to completing the template.			
Plan Management Webinar: Templates	**Q6:** Do issuers need to complete every segment of a module before the validator can check the submission?	**A6:** Yes. In the Issuer Module, the Issuer Submitter must complete all sections then click "Submit Application" on the Review page to move the application on to the next validation process. (Issuer Module User Guide, Section 5.2.13).	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q7:** Why is there an error message on the Product ID field?	**A7:** The Product ID is a 10 digit, alphanumeric, unique identifier. The Product ID consists of an Issuer ID, the State, and the 3-digit unique Product ID. In the Rating Business Rules Template, the Product ID is only given if the Issuer business rule does not apply to a given product. In the first row of the Ratings Business Rules Template, issuers should not enter a Product ID or a Plan ID as the first row is the default issuer-level rule. For each row after, issuers should not enter a Product ID and Plan ID on the same row; only one ID -- the Product ID or the Plan ID -- should be entered. The template does not validate the Product ID itself, it validates the format of the ID. If there is an error message on the Product ID field, it is related to the format of the Product ID.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q8:** Why do issuers get an error message	**A8:** The asterisk-labeled fields are always required. If there is ever an	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	for a required field that does not have an asterisk?	exception, there is no asterisk. There are data elements that may be required, depending on the situation and business rules, so there will be an error message that the field was required even though the field did not have an asterisk in the template.			
Plan Management Webinar: Templates	**Q9:** Why do issuers sometimes receive error messages, debugging messages, and have difficulty saving the template?	**A9:** All of the templates allow you to "Save As" and create multiple different copies. If you encounter problems, please contact the helpdesk with details on your problem. With the Plans and Benefits Template, these issues usually relate to the Add-in File. For best results: • Delete all previous versions of the Add-In File from your computer. • Save the latest version of the Add-in File in same the folder as the template. • Select the command "Save" button when downloading from a web browser. • Do not open the Add-in File from the web browser. • When saving the Add-in file, in the "Save" dialog box, make sure that the name and file extension is "PlansBenefitsAddIn.xlam." The Add-in will not work correctly if the name or file extension are different. When uploading the data into the system, it is an .xml file that is difficult to read. Once the file is uploaded and validated, the data is displayed once	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		again in the original Excel format in the template. When you open the regenerated template, you may see a message that the file needs to be recovered. This is an issue with the Java library. Click “ok” and then click through all the messages and the file will open normally with all data intact.			
Plan Management Webinar: Templates	**Q10:** Have the issues with the User Interface in HIOS been corrected?	**A10:** The issues with uploading supporting documents in the User Interface are fixed. The “Next" button is now displayed. Users that have both submitter and validator roles will need to navigate between sections of the Issuer module from the summary page to avoid the white screen issue.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q11:** When a person entering data completes the data entry, the user would then click the “validate” button, the errors would pop up that need to be fixed, the user would click the “validate” button again, and then lastly the user would finalize. The templates are all being completed separately. When that is all finished, is it at that point that	**A11:** Particularly if issuers are submitting through SERFF, make sure that the templates match each other. The Formulary ID, Service Area ID, and Network ID for each plan should match in the Plans and Benefits Template, Service Area Network, and Prescription Drug Templates. Each plan in the Plans and Benefit Template should have rates. This is the cross-validation that is done at the very end of the process. Make sure that that all matches before the final submission.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	issuers can have internal reviews of the templates, just before things are finally submitted?				
Plan Management Webinar: Templates	**Q12:** Regarding the sequence of review, does it happen at the end, after all templates are submitted, or can it happen after each module is completed? In other words, could management review module by module? Is there a preferred work flow?	**A12:** Issuers can review the templates in Excel before uploading them. Uploaded templates may be downloaded by the Issuer Submitter at any time. The Validator will only be able to view templates when the Submitter completes submission of the module. None of the modules: Issuer, Benefits and Service Area, Rating, or Rate Review require submission of any of the other modules before Validation.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q13:** Once the templates are submitted, is it too late to go back and correct things that may be found during a management review?	**A13:** Issuers can resubmit the templates any time in HIOS for the FFE (before April 30). Resubmissions are not restricted in any way; submitting a template does not make it final, nor does it stop an issuer from making changes. To revise a module or section that has been validated, the Validator will have to answer 'No' to the validation question to allow the Submitter to revise the submission. In the Issuer module, if you need to revise your submission after the validator clicks on the 'Submit Application' button on the Review page, you will need to call the help desk to	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		allow this change. Issuers applying into SERFF should consult with the state about their rules.			
Plan Management Webinar: Templates	**Q14:** Is the cross validation an automated process, or a manual process that issuers can perform?	**A14:** The cross validation can be manually initiated from the Issuer module, the Rates and Benefits module, or the Service Area module. The submitter can click the validate button at any time to perform the cross-validations - even if all the templates are not submitted. When the completed templates pass all the cross-validations, Issuers can make the submission to CMS. At this time, the cross validations will be performed automatically.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q15:** What is the format needed for the Tax ID number?	**A15:** The Tax ID field will accept nine (9) characters (no hyphen) or 10 characters (including the hyphen). If users enter 10 numbers, it will not pass validation.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q16:** Why are there issues with leading zeros in the Tax IDs, Health Insurance Oversight System (HIOS) Product IDs (HPIDs) and National Provider Identifiers (NPIs) on the template?	**A16:** This issue with the Tax ID is corrected in the current version of the template. HPIDs and NPIs do not begin with zero.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q17:** Why does the Administrative (Admin) Template not accept a phone	**A17:** There is a work-around procedure for this issue. Users should copy and paste the phone extension from another source into the cell (it will be accepted	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	extension beginning with a zero?	and will pass validation); users should not type a phone extension beginning with a zero directly into the template, because Excel will reformat the entry.			
Plan Management Webinar: Templates	**Q18:** What kind of information is required for the Admin Template in the "Proposed Exchange Market Coverage" field and the "Current Sales Market" field?	**A18:** The "Proposed Exchange Market" field indicates the market where the plan will be offered: "Individual," "SHOP," or "Both." The appropriate primary contact is required based on this value. The "Current Sales Market" field indicates where products are currently being offered. The same options, "Individual," "SHOP" or "Both" are in the drop-down. If there are no products currently offered in either the Individual or SHOP market, Issuers must select "Both."	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q19:** Which address should be entered in the Primary Contact field in the Administrative Template?	**A19:** The Issuer address should be the company address associated with the HIOS ID and entered in HIOS. The company address in HIOS is the relevant address for that issuer in that state. It needs to be entered in the "Primary Contact" field of the Administrative Template. The SHOP address should be the primary place of business in that state, not the employee address.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q20:** Is the "Primary Contact" information required to be the Chief Executive Officer (CEO) or the Chief Financial	**A20:** "The Primary Contact" information does not need to be the CEO or the CFO.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	Officer (CFO)?				
Plan Management Webinar: Templates	**Q21:** What does "Third Party Administrators" (TPA) mean in the Administrative Template?	**A21:** TPA is used for any vendor that provides services in the functional area listed. The information will provide a list of partners for potential interaction, such as secure routing of data.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q22:** On the Essential Community Provider (ECP) template, how do users enter a provider name that is associated with several different addresses? If the provider name is the same on several rows, the template will not validate.	**A22:** Please refer to the QHP Application Instructions that state that if the ECP has several locations, the issuer should add a number to the provider name to distinguish each location; for example, "Provider Name – 001." If the provider has a national provider identifier (NPI) number, only enter it with the first location of the provider and leave blank for all other locations.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q23:** Should the dental providers and pharmacies be included on the Essential Community Provider (ECP) spreadsheet? How are all the providers combined under single Network ID?	**A23:** Each QHP must be associated with a single Network ID. If the network has multiple parts, for example medical and dental, the medical and dental providers are combined under a single network ID. There is no need to submit pharmacies in the ECP network unless applying under the alternate standard. Alternate standard providers use the "Provider Type" column and have the option to check "Pharmacy" if the facility includes a pharmacy (which is purely for informational purposes and not for evaluation). Issuers applying	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		under the regular standard do not fill out "Provider Type"; but only fill out the "ECP Category" column. For those under the regular standard, there is no need to submit pharmacies as part of the ECP network.			
Plan Management Webinar: Templates	**Q24:** Should issuers submit the medical and dental together as a network?	**A24:** The entire network must be contained under one Network ID. The medical and dental must be combined, but not necessarily on one website. It is also acceptable if the link to the medical network has another separate link to the dental network.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q25:** Will there be any specific components of network adequacy related to the pharmacy network?	**A25:** CMS expects pharmacy will be part of the network and that the attestation to provide sufficient access to providers includes pharmacy access.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q26:** If the provider name is the same on multiple lines of the ECP template because there are multiple locations and issuers distinguish them with an additional number, how do issuers correct the error message because of the duplication of the NPI number?	**A26:** On the first instance for that provider, list the NPI number. On the subsequent locations, omit the NPI number so it does not trigger an error message in the duplicates check. The NPI is an optional field; omit it for multiple locations.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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Plan Management Webinar: Templates	**Q27:** In the Plans and Benefits Template, how will American Indian variations for plans for above 300% of the Federal Poverty Level (FPL), the limited cost share plans, be distinguished in the certification materials?	**A27:** Plans are certified at the Standard Component ID level. All cost sharing variants, including the Zero Cost Sharing and Limited Cost Sharing variants, must meet the QHP certification standards to be certified. On the Cost Sharing Variance worksheet of the Plans and Benefits template, the variants are distinguished by adding a code to the Standard Component Plan ID as follows: • 00 = non-exchange variant • 01 = exchange variant (not CSR) • 02 = Zero Cost Sharing Plan Variation • 03 = Limited Cost Sharing Plan Variation • 04 = 73% AV Level Silver Plan CSR • 05 = 87% AV Level Silver Plan CSR • 06 = 94% AV Level Silver Plan CSR	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q28:** Why does the Plans and Benefits Template have Column Q to indicate plan variation for a limited cost sharing variation or a zero cost sharing variation?	**A28:** Column Q on the Benefits Package is the Estimated Advanced Payment per Enrollee for the Limited Cost Sharing Plan, not the Zero Cost Sharing Plan. It is an optional field. The Estimated Advanced Payment amounts for the other Cost Sharing Variants are reported on the Unified Rate Review template.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q29:** What happens if there are blanks in the prepopulated area of the template?	**A29:** Although the fields may be required fields, blanks mean “Not covered.” No fields are required for benefits that are not covered.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q30:** What is the difference between	**A30:** If a benefit is not covered, it should be marked “Not covered” (or left	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	"Not Applicable" and "Not Covered"?	blank) in the benefits package. It will not display on the cost sharing sheet; the template will not indicate copayments or coinsurances for that benefit. "Not Applicable" is only an option for the Maximum Out of Pocket and Deductible fields on the Cost Share Variance sheet.			
Plan Management Webinar: Templates	**Q31:** Copayment and coinsurance are entered for specific benefits throughout the Benefits Template, although it is usually just one and not the other. How do Issuers indicate "No Charge," and how will that be displayed to the consumer?	**A31:** The consumer will see only the cost-sharing attribute that applies. For example, if there is a 20% coinsurance and $0 copay, only the 20% coinsurance will be displayed.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q32:** How do issuers indicate a benefit is not covered out-of-network and is covered in-network only?	**A32:** Issuers can indicate a benefit is not covered out-of-network by entering a 100 % coinsurance for the out-of-network cost sharing information for that benefit.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q33:** If a plan does not include an out-of-network benefit (except for emergency care), how do issuers complete the "Combined In/Out	**A33:** The issuer should complete the combined medical and drug in-network for that given benefit. If there is no coverage out-of-network, enter 100% coinsurance. The Deductibles and Maximum Out of Pocket fields have a "Not Applicable" option that can be selected for the Combined In/Out	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	Network" field of the Plans and Benefits Template?	Network fields. The benefits do not have a Combined In/Out of Network field.			
Plan Management Webinar: Templates	**Q34:** Why is there a warning message about exceeding the 2013 IRS Maximum Out-of-Pocket?	**A34:** Since the IRS has not yet established limits for 2014, the alert level is set at the 2013 out-of-pocket maximum to alert users that the maximum may be exceeded. There is more detailed information on how to address this in the QHP Application Instructions. The template will be able to validate successfully and be submitted.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q35:** How can the template accommodate more complex plan designs, such as custom deductibles or combinations of copays/coinsurances that are specific to the number of visits?	**A35:** Please refer to the detailed QHP Application Instructions, Chapters 10 and 11, for instructions on how to enter the coinsurance information/copay amount and how they map to Actuarial Value (AV) Calculator. Issuers can create up to five deductible groups for each benefit package. This option appears when you click on the "Create Cost Share Variance" macro button. Additional information can be provided to consumers using the "Exclusions" or "Explanations" text fields in the benefit package section of the template. Note that the fields in the AV Calculator Additional Benefit Design section of the template such as "Begin Primary Care Deductible and Coinsurance" and "Set Number of Copays" are for the Actuarial Value calculation and most likely will not display to consumers.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		Further, users can see more details about the plan benefits through the Uniform Resource Locator (URL) to the plan brochure.			
Plan Management Webinar: Templates	**Q36:** Do the benefits "generic drugs", "preferred brand drugs", "non-preferred brand drugs" and "specialty drugs" on the Benefit Template conflict with information entered to create a Formulary ID on the Pharmacy Template?	**A36:** The information that consumers will view is from the Benefits Template. There are detailed instructions on how to map the information from the Prescription Drug Template to the Benefits Template in Chapter 10 of the QHP Application Instructions.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q37:** The Plans and Benefits module only allows for one cost sharing amount per benefit; depending on the plan design, this could vary depending on the site of service; for example, chemotherapy (physician's office has a physician office copay; outpatient or inpatient facility has a deductible and coinsurance). How	**A37:** If there are provider types like Primary Care and Specialist, use them to differentiate the cost sharing. For others, if there is nothing available for a given benefit, where different cost sharing can apply depending on the site of service, the recommendation is to complete the copay or coinsurance that is typical for most enrollees, and using the explanation field for the appropriate and brief detail for the cost sharing and other scenarios, outside of the most common one entered in the standard data field.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	do issuers enter the site of service designation and appropriate cost share?				
Plan Management Webinar: Templates	**Q38:** There are some benefits listed that are not clear in the EHB section, such as domestic violence treatment. Is the treatment for physical injury or for counseling services? Is it for emergency room, a doctor's office, or a specialist's office?	**A38:** The information on the CCIIO website is a snapshot -- a summary of the benefits provided by the benchmark plan. Issuers can go to the NAIC website (http://www.naic.org/index_health_reform_section.htm) to locate the actual policy for that benchmark plan to see more detail about coverage, limitations, and exclusions. We would encourage issuers to work with their enforcing state to further understand what enforcement or review for EHB will entail.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q39:** Clarify whether an issuer can or must allow children to enroll in catastrophic plans. The rules talk about these plans being available to "young adults" and "under 30" but they do not address enrollment of children.	**A39:** There is no requirement to offer a child-only catastrophic plan. Section 1302(f) of the Affordable Care Act states that if a QHP is offered through the Exchange in any level of coverage specified under subsection (d), the issuer shall also offer that plan through the Exchange as a child-only plan. However, subsection (d) only addresses bronze through platinum coverage, whereas catastrophic level of coverage is in subsection (e).	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q40:** How do issuers work with State-mandated offers of	**A40:** The Federally-facilitated Exchange (FFE), including State Partnership Exchanges, will not collect	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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	coverage?	or display State-mandated offers of coverage. It is the issuer's responsibility to ensure these State-mandated offers of coverage are provided to consumers.			
Plan Management Webinar: Templates	**Q41:** If benefits that are must-offer/make-available/optional mandates in a State, are they required in the QHP Plans and Benefit Template submission?	**A41:** Must-offer/make-available/optional mandates in a State are treated like an optional rider. Those benefits that are "must-offer" mandates are not required to be included in the template. In situations where an issuer would traditionally offer a rider and is interested in offering that optional benefit on the Federally-facilitated Exchange (FFE), an issuer should submit two plans, one with and one without the rider. Depending on the benefit that would have been traditionally offered in a rider, it may not be displayed on the FFE website to consumers, but it may be displayed by issuers and provided to consumers in plan documents.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q42:** Do issuers have to file separate child-only policies for all of the QHP applications?	**A42:** Provided that child enrollees would be treated equally under the QHP as they would be under a child-only plan -- such that there would be no substantive difference between having a child-only plan and issuing child-only policies under the QHP (i.e., same enrollment opportunities, same premium rating, etc.) the issuer would not need to file a separate child-only plan. Separate child-only plans are not required for the Federally-facilitated Exchange (FFE) as	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		long as the QHP indicates it will accept child-only enrollees. In the FF-SHOP, children may only be added to an employee policy if the employee also enrolls. There may be instances when employees under the age of 21 enroll in an employee-only plan. In this instance, this would be considered child-only coverage.			
Plan Management Webinar: Templates	**Q43:** What about the fields for the data elements not collected (days supplied, quantity limit, cost sharing amounts other than for a one month or three month supply, etc.)?	**A43:** The purpose of the template is to collect enough information to determine that the formulary meets the Essential Health Benefit (EHB) and non-discrimination criteria, as well as to evaluate prescription drug coverage for certification. The consumers will only see information about the prescription drug coverage that is submitted in the Benefits Template. Consumers will be directed to the issuer's website (via the URL provided in the Formulary Template) for more detailed information about the prescription drug coverage. Also note that the deductibles and out-of pocket limits for prescription drug coverage are to be submitted on the Plans and Benefits Template.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q44:** How do issuers indicate the cost sharing and/or deductible subgroups for each tier?	**A44**: Each formulary will always take up seven rows. The rows to enter information for each tier will display when users enter the Formulary ID and number of tiers for each formulary in the steps below:	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		Step 1: Select the Issuer ID in the State. Step 2: Create the Formulary IDs (more Formulary IDs can always be added later by clicking the "Create Formulary IDs" macro button). Step 3: Select the first Formulary ID in Cell A-13. This will create rows for the cost sharing in tiers 1-7. Step 4: Select the number of tiers in the formulary. This will lock the tiers not used so that the correct number of tiers to enter the cost sharing information for each tier appears. Users can click on the next blank row in the template and repeat these steps for each formulary.			
Plan Management Webinar: Templates	**Q45:** On the template, how do issuers populate a separate brand and drug deductible that does not apply to tier 1 drugs?	**A45:** Issuers can create deductible subgroups on the Plans and Benefits template as outlined in Q44 and can refer to Chapter 10 of the QHP Application Instructions.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q46:** In the earlier versions of the template, the copay and coinsurance fields would not accept zero. Has this been corrected?	**A46:** These fields will now accept a zero value for the one month retail cost sharing; it is corrected on the final version of the template.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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Plan Management Webinar: Templates	**Q47:** How does the Formulary Template work?	**A47:** The Formulary ID is a combination of the drug list on the second tab and the cost sharing structure. Issuers can use the same drug list for multiple cost sharing structures; each combination of drug list/cost sharing structure should have a unique Formulary ID. Only a single Formulary ID can be associated with a plan.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q48:** Where do issuers get access to the drugs listed in each category and class that are making up the state benchmark count?	**A48:** As stated in the EHB final rule, published 2/25/13 at 78 FR 12834, the regulatory standard for EHB compliance does not require that issuers cover the same drugs as the EHB benchmark, only the greater of one or the number of drugs in each United States Pharmacopeia (USP) category and class. As such, CMS published the drug count service. Issuers may use publicly available sources to research the benchmark (available at: http://www.naic.org/index_health_reform_section.htm). If issuers are having problems meeting the count because the USP Category Class Count Service (Count Service) is not recognizing drugs being submitted, please contact the Helpdesk.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q49:** How do issuers include drugs that do not have an RxNorm Concept Unique Identifier (RxCUI) associated to them?	**A49:** Issuers can offer drugs that are not counted in the drug count service and may include this information in the formulary list available on their website. Additionally, issuers may submit supporting documentation.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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Plan Management Webinar: Templates	**Q50:** How does the copy/paste function work from one version of the Rating Template to the next?	**A50:** Users should select and copy all the rows in the previous template, starting below the header and continuing all the way to the end. In the new template, users should paste starting in the first row below the header. Do not click "Paste Values As," just click "Paste," conserving the original formatting.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q51:** How do the age bands work in the Rating Template?	**A51:** The age bands are automated; users do not need to enter ages since they will automatically display. Once any age is selected, the template will populate "0 through 20" and the other age bands required. Users just need to enter the rates.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q52:** On the Business Rules Template, is there a maximum age for a dependent? Is this field related to the dependent price capping or is it related to the dependent eligibility?	**A52:** The maximum age for a dependent field is related to dependent eligibility. This is the maximum age a child can reach to be to be covered under the QHP as a dependent. States may increase the maximum age for a child-dependent through state law. For instance, a state could determine that any child under the age of 30 must be offered coverage on a policy. (It does not affect calculating the family premium or the market rules under 45 CFR 147.102(c)(1), which states that the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.)	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: Templates	**Q4:** The Customer Service TTY field	**A4:** Please use your Customer Service phone number if there is no 10-digit	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	asks for a 10-digit number, but TTY values are usually three digits. We inputted 711 as our TTY number since the FCC established the 711 telecommunications relay service (TRS) in order to make the process easier and more reliable for the hearing impaired. However the field requires a 10digit number. Do you not accept the 711 number? If not, do we need to create a new 10 digit TTY number?	TTY number.			
Plan Management Webinar: Templates	**Q5:** We have found when entering information into the administrative template that any ID which begins with a "0" drops the "0" and shorts the number by 1. For example, tax ID number 06-1475928 displays as 61-475928. Because	**A5:** All tax IDs now accept leading zeros in the templates. Valid HPIDs and NPIs do not begin with leading zeroes. For any field where this remains an issue, you may copy paste the value from another document into the template.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	a dash is placed after the first two numbers and the "0" place holder disappears, the template makes it look as though we've entered an incorrect number.				
Plan Management Webinar: Templates	**Q2:** On the administrative template, is the term Third Party Administrators (TPA) indicative of vendors or any companies outside of our organization performing a service specific to the three functional areas referenced?	**A2:** We use the term "TPA" to apply to any vendors that provide services in the functional areas listed. This information will provide a list of partners for potential interactions such as secure routing of data. Later this year, we will ask TPAs to register in HIOS so that issuers can link to their TPAs for different markets when applicable.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: Templates	**Q3:** We encountered an invalid issuer legal name system error when uploading the file in the administrative template. How do we upload the file?	**A3:** The Issuer legal name must match exactly the name associated with your Issuer ID in HIOS.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: Templates	**Q60:** Can the templates be validated and finalized from a SharePoint site?	**A60:** Depending on your organization's settings, it may not be possible to use the Plans and Benefits template from a network drive or SharePoint site. The Import IDs and Check AV Calculation	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		macros require you to browse for additional files. In general, you will get best results if you work with the templates on a local drive. You may store the saved versions anywhere.			
Plan Management Webinar: Templates	**Q61:** If an issuer has an ER copay of $150, which covers the facility charge part, but at the same time the member will be billed the physician part subject to deductible and coinsurance, how should the template be filled out?	**A61:** The template cannot accommodate the described situation where the facility charge is not subject to deductible/coinsurance but the physician/professional charges are. The issuer should fill out this benefit identical to how it would complete the stand-alone AV Calculator. We recommend that the issuer use whichever charge typically is predominant for consumers. For example, if the facility charge typically makes up the majority of the total allowed costs, then input the facility portion of the benefit into the data fields and enter the physician portion into the free text explanations field.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q62:** Do the silver cost reduction variations need to be submitted with separate standard component IDs?	**A62:** No. The template on the Cost Share Variances tab will automatically add suffixes to the standard ID for the appropriate cost sharing reduction variations.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q63:** In the Cost Share Variances tab, are issuers expected to run the SBC calculator and input numbers into the	**A63:** As noted in Chapter 10 of the instructions, this template section contains fields for basic information about two SBC scenarios. While these data fields are optional, issuers are advised that the FFE may be using	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	columns L-S?	certain data elements from the SBC in Plan Compare. If this issuer does not provide this information, then Plan Compare will show "not available."			
Plan Management Webinar: Templates	**Q64:** Is there documentation on the macros in the plan_management_data_templates_plans_benefits workbook or add-in? Where can issuers find the source code?	**A64:** There are several documents available on zONE to give you more detailed technical information about the templates, including: • Data Traceability Matrix (DTM) • Data Dictionary • Populating FFE Spreadsheets By Developers	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q65:** How should plans represent a sanction for out-of-network claims?	**A65:** In the case of a monetary penalty that cannot be defined using the copay and coinsurance fields, the issuer may use the Explanations fields (at the benefits level) or the Plan-Level Exclusions field to describe the extra cost sharing associated with out of network sanctions.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q66:** What should issuers enter in the out-of-pocket maximum fields if there are no separate drug and EHB benefits?	**A66:** If the plan does not have separate medical and drug deductibles or maximum out-of-pockets (MOOPs), you should use the "Medical & Drug Deductibles Integrated?" or "Medical & Drug Maximum Out of Pocket Integrated?" fields on the Cost Share Variances tab of the Plans & Benefits template to indicate that the deductibles or MOOPs are integrated and not separate. Answering "Yes" to these fields will grey out the separate deductible or MOOP fields, so that you	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		only need to enter deductibles or MOOPs in the "Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)" or "Combined Medical and Drug EHB Deductible" fields, respectively. If you have integrated deductibles or MOOPs, only one individual deductible or MOOP and one family deductible or MOOP will be displayed to consumers on the Plan Compare website.			
Plan Management Webinar: Templates	**Q67:** For an HMO copay driven plan that does not have out-of-network benefits or coinsurance applied, what should be entered in the template?	**A67:** For a benefit category where there is a copay, but no coinsurance applies, enter "No Charge" in the coinsurance field. For a benefit category that does not have out-of-network benefits, enter $0 in the out of network copay field and 100 percent in the out-of-network coinsurance field.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q68:** How should we complete Column Q "Limited Cost Sharing Plan Variation - Est Advanced Payment?	**A68:** Please refer to Chapter 10: Instructions for the Plans & Benefits Application Section regarding how to complete the Plan & Benefits Template. The "Limited Cost Sharing Plan Variation—Estimated Advance Payment" is an optional field. Leaving column Q, "Limited Cost Sharing Plan Variation - Est Advanced Payment" blank indicates that the issuer does not request advance payments for the value of cost-sharing reductions provided under the limited cost sharing plan variation for the QHP associated with	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		the benefit template. As indicated in the HHS Notice of Benefit and Payment Parameters for 2014 (available at: http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), QHP issuers may, but are not required to, estimate the value of cost-sharing reductions that they will provide through their limited cost sharing plan variation if they wish to receive advance payments from HHS. Issuers that choose not to submit such estimates by leaving column Q blank must still provide the cost-sharing reductions to enrollees in the limited cost sharing plan variation, and will be reimbursed by HHS at the close of the benefit year. More information on issuer options with respect to such estimates is included on page 15495 at the link above.			
Plan Management Webinar: Templates	**Q69:** Are issuers required to list medical necessity as a requirement for all benefits?	**A69:** It is not required for the issuers submit medical necessity with each covered benefit.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q70:** How should an issuer indicate that it covers a benefit in limited circumstances?	**A70:** If an issuer covers a benefit in limited circumstances, it should indicate that the benefit is covered and use the Exclusions and/or Explanations field to describe the circumstances in which the benefit is covered. Please do not enter any information into the Exclusions and Explanations field if a benefit is not covered.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
(HHS/CCIIO; Labor; Treasury/IRS)

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Plan Management Webinar: Templates	**Q71:** What should issuers fill in if none of the EHB Variance options are appropriate for the scenario?	**A71**: As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, a comprehensive list of EHB variance reasons is identified. If you believe that none of the reasons are appropriate, please select "Other Law/Regulation" and provide an explanation.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q72:** If an issuer enters a 100% coinsurance plan with a deductible and OOP of $3,000 and then change the OOP to $4,000, why does the AV change, even though there is no coinsurance applying to the additional OOP?	**A72:** When the user changes the MOOP, the AV should change because the plan is changing its cost-sharing parameters, which is what the AV is measuring. Also, please note that the AV Calculator User Guide clarifies that the plan should not specify a 100% General Coinsurance Rate unless specifying a copay based plan. Therefore, when inputting 100% General Coinsurance, the calculator is anticipating cost-sharing on the copay side.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q73:** Could HHS clarify the purpose of the POS label on the tier 2 portion of the AV Calculator, given that the Calculator is not meant to be used for plans that include out-of-network?	**A73:** Per the AV Calculator Methodology document (http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf), the AV Calculator produces estimates of actuarial value based only on in-network services and allows the user to specify only in-network cost-sharing parameters. This is consistent with 45 CFR 156.135(b)(4). The final version of the AV Calculator can accommodate plans utilizing a multi-tiered in-network plan design with up to two tiers of in-	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		network services. Users may input separate cost-sharing parameters—such as deductibles, coinsurance rates, MOOPs, and schedules for service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting actuarial value is a blend of the AV for the two tiers.			
Plan Management Webinar: Templates	**Q74:** How should the impact of excluded or limited-coverage EHBs (e.g., a closed formulary pharmacy design meeting benchmark minimums) be addressed in the calculation of actuarial value?	**A74:** For the purpose of calculating actuarial value, the user only needs to specify the plan's cost-sharing for the four tiers of prescription drugs: generics, preferred brand drugs, non-preferred brand drugs, and specialty drugs.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q75:** If an issuer has a higher co-pay on a benefit not specified on the AV Calculator, is the plan compatible with the AV Calculator?	**A75:** In the 2014 Letter to Issuers released on April 5, we provide two examples of plans that are not compatible with the AV Calculator. See the discussion in Appendix C, starting on page 56. We also state that a plan design that includes different cost sharing for services not included in the AV Calculator would be considered compatible with the AV Calculator.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q76:** If a company has eight plans available in six service areas, how	**A76:** In the Plans and Benefits template, a plan ID is associated with one Service Area ID, Network ID, and Formulary ID. Each Service Area ID, Network ID,	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	should they be listed in one template to avoid errors?	or Formulary ID may be associated with multiple plans in the Plans and Benefits template. In the Service Area template, a county may be included in multiple Service Areas. The applicant needs to create a Service Area ID for each unique combination of counties (or partial counties) that is covered by a single plan. If more than one plan covers the same Service area, then both plans can use the same Service Area ID.			
Plan Management Webinar: Templates	**Q77:** Should issuers include the 94%, 87% and 73% Silver Tier plans and benefits to the templates? How do issuers identify that these are the various levels of a Silver Plan? Is that the Unique Plan Design Column?	**A77:** *As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, complete the Plan Identifiers section for each standard plan you want to create for a benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage, and a benefits package is a group of plans that cover the same set of benefits; each plan in a benefits package can have different cost sharing, which is defined in the Cost Share Variances tab. After the benefit-related information is completed, click the "Create Cost Share Variances" button on the menu bar under the Plans and Benefits ribbon. The Cost Share Variances tab is designed to collect more detailed cost sharing benefit design information for all plans and cost-sharing reduction plan variations submitted by the issuer. A new worksheet, "Cost Share Variances," will be created for each Benefits	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		Package worksheet. The template will automatically create rows for the appropriate cost-sharing reduction plan variations. For example, if the standard plan is a silver plan, the template will create five different plan variations. These plan variations are not related to the "unique plan design" column. The "unique plan design" refers to whether or not the plan design can be evaluated using the actuarial value calculator. * Edited on 4/26/13			
Plan Management Webinar: Templates	**Q78:** How do you add a row for more product IDs?	**A78:** If you run out of empty rows for new plans, click the "Add Plan" button on the menu bar under the Plans and Benefits ribbon and a new row will appear for an additional plan. Each benefits package can have up to 50 plans. If you have more than 50 plans associated with the same benefit package, you will have to create a new benefit package with the identical plan structure.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q79:** If an issuer wants to file a Platinum Plan to sell off-Exchange, but doesn't want it on the Exchange, should an issuer still add the plan to the template?	**A79:** Do not submit information to the FFE for plans that you do not want made available on the Exchange.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q80:** Do issuers need to list all of their specialists in	**A80:** On the Plan & Benefits Template, users must enter all of the specialist types in the 'Specialists Requiring a	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	the "Specialists Requiring a Referral tab" text box?	Referral' tab.			
Plan Management Webinar: Templates	**Q81:** Does the "Plan Level Exclusions" tab refer to the entire list of exclusions for each plan?	**A81:** On the Plan & Benefits Template, in terms of the "Plan Level Exclusions" users may list all exclusions of the insurance plan at the plan level; this applies to all benefits. Users may also refer to Chapter 10: Instructions for the Plans & Benefits Application Section for additional information.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Templates	**Q63:** What network ID should an issuer use for a network consisting of other networks?	**A63:** Each QHP submitted must be associated with a single Network ID as identified in the Network ID Template. If an issuer has, for example, three networks associated with a given QHP, the issuer will need to create a fourth Network ID consisting of those three networks, and use that single ID for completing the Benefits Template.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q64:** What should issuers enter for the field "User Access Contact" on the administrative template?	**A64:** The optional User Access contact should be supplied if the issuer would like to have a single point of contact for addressing issues related to HIOS system access.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q65:** Is there a policy limit to the number of children on a SHOP plan? How should the Business rules template field "number of children	**A65:** There is no limit on number of children covered in a SHOP. The selection specifically states 1, 2, or 3-or-more. Limiting it to a maximum of 3 (or more) children is strictly for purposes of pricing the family rate. It does not mean there is a limit on the number of children that could be on a given policy.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	allowed under a contract-only SHOP" be completed?				
Plan Management Webinar: Templates	**Q66:** How should an issuer indicate any exceptions to this limiting age? For example, if an issuer operates in a State that requires coverage of dependents older than age 26 if they are disabled.	**A66:** If certain other types of dependent are allowed, this can be noted in the final column on the business rules template, which asks what dependent relationships are allowed.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q67:** Can issuers use the column "Drug Tier Type" in the prescription drug template to indicate specialty drugs?	**A67:** Please use the "Only select brands" option in the Drug Tier Type field to indicate that the tier is a specialty drug tier.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q68:** Can an administrative template contain more than one Issuer ID?	**A68:** Issuers must submit a single application for each Issuer ID.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q69:** If an issuer intends to offer some identical plans on and off the Exchange in the individual market in order to take advantage of protections available through the 3Rs, the	**A69:** By selecting "both," the issuer is indicating that the plan will be offered both on and off the Exchange.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	issuer must have a unique Component ID. In the Plans & Benefits Template, should the issuer select "on-Exchange," "off-Exchange," or "both" for the component identifier?				
Plan Management Webinar: Templates	**Q70:** If an issuer does not cover routine foot care except in the case of a diabetes diagnosis, how should the issuer list Routine Foot Care on the QHP template?	**A70:** Issuers should place any additional limitations in the Explanation field for Routine Foot Care. Any benefit level exclusions should be placed in the Exclusions field for Routine Foot Care. Please refer to Chapter 10: Instructions for the Plans & Benefits Application Section for more information. The Instructions can be found on the zONE or at https://www.REGTAP.info/.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q71:** How should issuers use the fields "1st tier and 2nd tier utilization"?	**A71:** If the plan applies different levels of in-network cost sharing depending on the tier of the provider or facility, indicate that the plan has multiple in-network tiers in the Plans & Benefits template. For plans with multiple in-network tiers, you are required to enter the proportion of claims cost that is anticipated to be utilized in each tier. These utilization amounts are entered into the "1st Tier Utilization" and "2nd Tier Utilization" fields in the Plans & Benefits template. If the plan does not have multiple in-network tiers, "1st Tier	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		Utilization" will be pre-populated to 100% and "2nd Tier Utilization" will be grayed out.			
Plan Management Webinar: Templates	**Q72:** How should issuers fill in the field "Plan Effective Date"?	**A72:** As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, the Plan Effective Date is a required field. It must be January 1 for individual market and SHOP. The instructions can be found on the zONE or at https://www.REGTAP.info/.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q73:** How does an issuer complete the Copay and Coinsurance columns in the cost share variance worksheet under the following scenarios: (a) the cost sharing for a particular benefit varies based on place of service (b) the cost sharing for a particular benefit varies based on provider type (i.e., specialist copay versus PCP copay)?	**A73:** The Cost Share Variance worksheet does not allow copays or coinsurances to vary for a particular benefit based on place of service or provider type. The Actuarial Value Calculator can only accommodate a single coinsurance rate or copay for each benefit. If you have multiple coinsurance rates or copays for a single benefit, then you should consider this plan to be a unique plan design (and indicate this on the Benefit Package worksheet) and fill out the necessary supporting document, and an actuarial certification for unique plan design, as set forth in 45 CFR 156.135.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q74:** Should each benefits package be created on a separate tab?	**A74:** Each benefit package needs to have its own tab. If you want to create additional benefits packages, click the "Create New Benefits Package" button on the menu bar under the Plans and	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		Benefits ribbon. The HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan, and TIN fields will be auto-populated. If the benefit package for all of your products and plans is identical, only one benefit package tab is needed.			
Plan Management Webinar: Templates	**Q75:** Rather than importing the Service Area IDs, Formulary IDs and Network IDs, is it possible to manually enter them in?	**A75:** Yes, issuers may manually enter the IDs. However, the IDs must match the IDs that are generated in the Service Area, Prescription Drug, and Network ID templates.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q76:** Is there a problem with the benefits template that requires leaving cells for outpatient surgery and prescription drugs blank?	**A76:** You should be able to run plans with outpatient surgery and prescription drug cost sharing inputs. However, please note that the Chapter 11 Plans and Benefits Template Instructions on Actuarial Value provide some specific guidance on inputting these items: 1) The AV Calculator does not support copay values for the Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services benefit categories. If either of these benefit categories has a copay in the Plans & Benefits template, the AV Calculator will return an error. For purposes of the AV Calculator, issuers may convert a plan's Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services copay into an estimated coinsurance and enter this coinsurance into the Plans & Benefits template. 2)	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		The AV Calculator does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance are entered for a drug benefit in the Plans & Benefits template, the AV Calculator will return an error. This document is available at: https://www.REGTAP.info/uploads/library/Chapter_11_Ver1_3_042213.pdf			
Plan Management Webinar: Templates	**Q77:** Are medical copay amounts considered when using the AV calculator macro?	**A77:** Yes, the medical copay amounts are considered in the AV Calculation of the Plans and Benefits Template. Specifically, if you refer to the Plans and Benefit Template Chapter 11 Instructions on Actuarial Value, there is a section that explains how the Plans and Benefits Template maps to the data inputs to the stand-alone AV Calculator inputs. This document is available at: https://www.REGTAP.info/uploads/library/Chapter_11_Ver1_3_042213.pdf	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q78:** Do all limits need to be identified, or can issuers list one limit and then state "other limits apply"?	**A78:** Per 45 CFR 156.115, plans must have benefits that are substantially equal to the benchmark. EHB plans may include quantitative limits that are substantially equal to quantitative limits in the benchmark. Both the medical plan template and the dental template provide an area for plans to describe both limits that are present in the benchmark or other limits. While we encourage detailed provision of any benefit limits, there is no requirement that every limit	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		in the plan is input in the plan's application. Issuers may include additional details in the explanations field and plan brochure to inform consumers about the plan's limits.			
Plan Management Webinar: Templates	**Q79:** Does every exclusion need to be noted in the template? If an issuer does not list a benefit as excluded, is it assumed to be covered?	**A79:** As noted in Chapter 10: Instructions for the Plans & Benefits Application Section Exclusions is an optional field in the Plan & Benefits template. Issuers may enter any benefit level exclusions in this field if particular services or diagnoses are subject to exclusions (covered under some circumstances but not others) or if no services or diagnoses are excluded, leave this field blank. Information regarding exclusions will help inform consumers, and additional information may be included in the plan brochure. The instructions are available on the zONE or at https://www.REGTAP.info/.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Templates	**Q80:** In regards to relating to differing PCP visits on a CSR variant plan in the Plans & Benefits template: The 'Begin Primary Care Cost-Sharing after a Set Number of Visits?' input is only set once in the Plans & Benefits template and therefore cannot	**A80:** As described in 45 CFR 156.420, silver plan variations must have equal or more generous cost sharing with respect to each essential health benefit than the standard silver plan or any other silver plan variation with a lower actuarial value (AV). This includes cost sharing parameters described in the Plans and Benefits Template as "Begin Primary Care Cost-Sharing After a Set Number of Visits," "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays" and "Set a	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	differ among silver plan CSRs and limited cost sharing plan variations. How should an issuer complete the Plans and Benefits template for this issue? Should this be a unique plan design with an included screenshot or is there something else that an issuer should be entering in?	Maximum Number of Days for Charging an IP Copay?" However, since the QHP issuer cannot change the these inputs in the Plans and Benefits Template for the silver plan variations without modifying the standard silver plan design, a QHP issuer wanting to provide more generous cost sharing through these parameters would need to designate that particular standard silver plan and its plan variations as a unique plan design using the "Unique Plan Design?" field of the Plans and Benefits Template. The QHP issuer should then calculate the actuarial value of the plan variation using the stand-alone AVC, and input the more generous cost sharing parameters. The QHP issuer must then complete the "Issuer Actuarial Value" data field with the value from the stand-alone AVC for the appropriate plan variations. The QHP issuer should also upload a screen shot of the stand-alone AVC for the plan variations with the more generous cost sharing parameters, as a supporting document for each plan variation for which this situation occurs. They should indicate the HIOS Plan ID (Standard Component) in the Description field when uploading the screen shot as a supporting document in HIOS as well as indicating the HIOS Plan ID (Standard Component) in the file name of the screen shot. Note that the QHP issuer			

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		will need to follow this same process for the standard silver plan on which these plan variations are based. Please note that in this situation designating the plan as a unique plan design will not require submission of an actuarial certification and you will not be considered unique for review purposes. QHP issuers should also note that the "Begin Primary Care Cost-Sharing After a Set Number of Visits," "Begin Primary Care Deductible/Coinsurance After a Set Number of Copays" and "Set a Maximum Number of Days for Charging an IP Copay?" fields should reflect the values for the standard plan – not the plan variations. We note that these data elements will not be displayed on the Plan Compare website. Lastly, QHP issuers should note that pursuant to 45 CFR 156.420(d) they may NOT change the values of these parameters for the zero cost sharing plan variation or the limited cost sharing plan variation of any of their QHPs.			
Plan Management Webinar: Templates	**Q81:** Will the MOOP be changed from $6400 to $6350 for 2014?	**A81:** At the time of writing this response, the IRS has not issued this number yet. Per the Letter to Issuers released on April 5,"In the FFE, if IRS-published limits are below $6,400/$12,800, HHS will flag QHP applications with out-of-pocket maximums above the allowed amount. Affected issuers will be permitted to revise their out-of-pocket maximums	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		during the resubmission window built into the QHP certification process. HHS will allow issuers to adjust other associated data elements for affected plans if necessary. For example, issuers will be permitted to modify other cost-sharing parameters in order to maintain an actuarial value (AV) consistent with the standards of 45 CFR 156.140." The Letter to Issuers on Federally-facilitated and State Partnership Exchanges, published on April 5, 2013, is available at: http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf HHS encourages States, particularly those participating in a State Partnership Exchange, to use this approach to allow updates during the revision window. States may instruct issuers to follow an alternate process to correct deficiencies of this type of issue.			
Plan Management Webinar: Templates	**Q82:** For a limited cost sharing plan variation of a QHP that does not cover services when furnished by an out-of-network provider, does the cost sharing need to be eliminated for EHB out-of-network services furnished directly by the Indian Health	**A82:** As discussed in Q&A 27 of QHP FAQ #3 (published on REGTAP on April 11, 2013) in relation to the zero cost sharing plan variation, enrollee spending for non-covered services is not considered cost sharing. As a result, if a QHP does not cover certain services (or all services) furnished by a provider outside of the network, the spending for these non-covered services would not need to be eliminated for the zero cost sharing plan variation or the limited cost sharing plan variation, even if the	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services?	service was furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services. QHP issuers, including HMOs, should note however, that reimbursement is required in compliance with section 206 of the Indian Health Care Improvement Act. In general, QHP issuers should be aware that they can indicate that a service is not covered by marking the service as not covered on the Benefits Package Worksheet, or, if a service or no services are covered when furnished by an out-of-network provider, the QHP issuer can set the out-of-network coinsurance for the service(s) to 100%, set the out-of-network copay(s) to "no charge," and indicate that enrollee spending for those service(s) does not count towards any deductible or towards any maximum out-of-pocket limit. In addition, as discussed in Chapter 10 of the Plans and Benefits Application, QHP issuers should be aware that the cost-sharing reductions under the limited cost sharing plan variation do not need to be recorded in the Plans and Benefits Template.			
Plan Management Webinar: Templates	**Q83:** How should QHP issuers indicate HSA eligibility if the standard plan is HSA eligible, but one of	**A83:** If a QHP issuer chooses to offer an 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	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	the cost-sharing reduction plan variations is not HSA eligible?	Eligible" field on the Plans & Benefits template.			
Plan Management Webinar: System for Electronic Rate and Form Filing (SERFF)	**Q27:** How does the plan information get into HIOS for HHS to review once the issuer submits through the SERFF system? Will the SPE QHPs submitted by the issuer to SERFF be automatically transferred to HIOS, or will we need to submit them to HIOS as well?	**A27:** In States in which an SPE is operating, transfer of the issuer's QHP application data from SERFF to HIOS will take place after the State has reviewed the applications. The State will select recommended plans and then initiate the transfer of recommended QHPs' data to HIOS.	FAQ April 8, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_040813.pdf
Plan Management Webinar: System for Electronic Rate and Form Filing (SERFF)	**Q45:** After issuers in State partnership States complete their application in SERFF, what further steps are required?	**A45:** States will communicate with issuers about the status of their applications once completed in SERFF.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: 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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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		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.			
Plan Management Webinar: Compliance Plans	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Compliance Plans	**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	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf

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		in offering future guidance.			
Plan Management Webinar: Compliance Plans	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Compliance Plans	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Compliance Plans	**Q32:** For the organizational chart submission, our assumption is that you are looking for an organizational chart with the CEO and key leaders versus Corporate Entity/Issuer Org Chart. Is that correct?	**A32:** Yes, that is correct.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Compliance Plans	**Q33:** For the QHP compliance plan, do you prefer our current plan with acknowledgement that it will be adjusted for ACA, or do you want the current draft of our plan knowing it is	**A33:** HHS understands that compliance plans are subject to change as an entity evolves, and HHS assumes that an effective compliance strategy encompasses an issuer's full lines of business. We would expect issuers to update their existing compliance plans to reflect new Federal standards that may apply as a result of the issuer's participation in the FFE. If Exchange-	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	only a draft? When do you expect to have our approved compliance plan?	specific updates are not presently made, we recommend that an issuer submit the existing compliance plan to assist HHS in offering future guidance. For issuers that are currently drafting a compliance plan that would include Exchange-specific information, we suggest submitting the revised compliance plan that is pending approval. This will better help us to see the Exchange-specific information.			
Plan Management Webinar: 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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Network Adequacy	**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.	FAQ April 9, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs_2_040913.pdf
Plan Management Webinar: Network Adequacy	**Q14:** If an issuer has different networks for dental, vision, and medical, should	**A14:** Each QHP must be associated with a single Network ID. If an issuer has dental, vision, and medical networks for a QHP offering all three types of	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	all three be submitted?	benefits, the network URL provided in the Network ID template should provide the consumer access to view all three networks. If an issuer is Tier 3 and is submitting a network access plan, that plan should describe standards applicable to all three parts of the network. See the Chapter 6 of the Instructions for more information on Network Adequacy reviews. An issuer offering dental benefits should also include its dental providers in the ECP network provided through the ECP template. A list of dental ECPs is available here: https://data.cms.gov/dataset/List-of-Essential-Community-Providers-ECPs-that-Pr/nwve-k4qu.			
Plan Management Webinar: Network Adequacy	**Q35:** If an issuer is accredited, can it skip the Network Adequacy section?	**A35:** Issuers must respond to all sections of the QHP Application, including Network Adequacy. The Network Adequacy section does not use a template, but has attestations that all issuers must complete in the QHP Application System. As noted in the Letter to Issuers, in States without sufficient network adequacy review HHS will accept an issuer's accreditation (commercial or Medicaid) from an HHS-recognized accrediting entity. Unaccredited issuers will be required to submit an access plan as part of the QHP Application. The access plan must demonstrate that an issuer has	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		standards and procedures in place to maintain an adequate network consistent with 45 CFR156.235(a). Accredited issuers are still required to submit their Essential Community Provider (ECP) networks via the ECP template.			
Plan Management Webinar: Network Adequacy	**Q36:** Are the network adequacy standards for FFEs the same as for Medicare Advantage?	**A36:** The network adequacy standards in the application apply to the FFE. They are different from the standards used in the Medicare Advantage program. Exchange network adequacy standards can be found at 45 CFR 156.230. More information is also in Chapter 1 of the Issuer Letter.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Network Adequacy	**Q37:** What is the definition of a network?	**A37:** A network is the system of health care providers offered by a specific plan.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q7:** If an uploaded document is incorrect, can issuers upload a new document to replace it?	**A7:** Yes.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Technical Guidance	**Q8:** What format do uploaded supporting documents need to be in?	**A8:** Supporting documents can be uploaded as PDF or Word formats.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Technical Guidance	**Q9:** How do issuers correct errors found upon final submission (cross template validation) if it is not possible to change the	**A9:** For states using the FFE, the validator can reverse the validation decision to allow revision of the submitted data during the initial submission period. For states using the System for Electronic Rate and Form Filing (SERFF), issuers will need to	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf

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	information once the data validation has been performed?	manually validate that each plan has a valid network, service area, and prescription drug ID; that there are rates submitted for each plan; and that they have submitted the rating rules template.			
Plan Management Webinar: Technical Guidance	**Q10:** What documents can be deleted or overwritten after they are uploaded in the QHP application?	**A10:** For templates, a newly uploaded template will overwrite the previous template in the Issuer, Rating and Benefits, and Service Area Modules. Supporting documents may be deleted in the Issuer Module. Supporting documents may not be deleted in the other modules. In the Benefits and Service Area module, issuers may use the comment field to indicate that an updated version has been submitted.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Technical Guidance	**Q11:** Will HHS provide validation reports when issuers submit the templates? Will issuers be able to correct errors during the application window?	**A11:** Every template has a validate button. After you upload the template, the system will complete a validation. There is an update status button to check the status. There is an error report delivered on screen.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: Technical Guidance	**Q50:** How can issuers determine if and how a template has changed from what is currently available on the SERFF website compared to what is available on the Plan	**A50:** All templates contain a version number. Use that number to determine whether the SERFF template is the same as the one on the one from the Plan Management Tool.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	Management tool?				
Plan Management Webinar: Technical Guidance	**Q51:** When will the final user guide for QHP submission through HIOS will be available and where users will be able to obtain the user guide?	**A51:** The most current HIOS portal user guide is available at http://cciio.cms.gov/resources/other/ under the section titled "Content Requirements for Healthcare.gov." The complete instructions for submitting the QHP Application can be found at http://www.REGTAP.info.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q52:** Can issuers submit more than one attachment?	**A52:** In the Issuer Module, each supporting document is a single upload. If you upload a document again, it will replace the previous upload. In the Benefits and Service area module, you can upload multiple 'other' supporting documents. The Rating module does not require supporting documents.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q53:** Can a partially completed template be stored in the system?	**A53:** You cannot download or upload partially completed templates. We recommend that you download the template and save to your local drive, then enter data. Once you complete the template, save it on your local drive then upload the XML generated by the completed template.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q54:** When are the zip codes provided in the Service Area Template validated?	**A54:** The zip codes are validated after the template is uploaded and processed.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q55:** Are there special character limitations in text fields?	**A55:** This depends on the field and if the field is in a template or on the User Interface. The HIOS User Guide provides the valid characters for the fields in the templates. If it is a field on	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		the User Interface, there are no special character limitations in text fields.			
Plan Management Webinar: Technical Guidance	**Q56:** If an issuer has multiple Issuer IDs, will the issuer need to complete multiple plan and benefits templates?	**A56:** Yes, the issuer would require multiple Plan and Benefit Templates. However, the issuer would be able to use the same add-in file for all of the templates as long as the add-in file was stored to the same hard-drive as all the benefits templates. Note: It is recommended that the issuer not have more than one Plan and Benefit template open at once.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: Technical Guidance	**Q57:** Do separate Plan and Benefits templates need to be completed for the SHOP and Individual markets if the issuer is submitting for both markets?	**A57:** Yes, each application would require a SHOP and Individual template. However, the issuer would be able to use the same add-in file for all of the templates as long as the add-in file was stored to the same hard-drive as all the benefits templates. Again, we recommend that the issuer not have more than one Plan and Benefit template open at once.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: USP/Pharmacy	**Q19:** What is the format for the USP Category and Class Count input file?	**A19:** The USP Category and Class Count service input file must contain a header line that reads "RXCUI," (not case sensitive), must not contain any blank lines, must contain RxCUI's that contain only numbers, and are no longer than 8 digits in length (any leading 0's will be truncated). For more information about this file, please see section 4.2 of the User Guide.	FAQ April 11, 2013	CMS	https://www.regtap.info/uploads/library/QHP_FAQs3_041113.pdf
Plan Management Webinar: USP/Pharmacy	**Q39:** We have several concerns on	**A39:** The purpose of the template is to collect enough information to determine	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	the prescription drug template: (1) The enterprise-assigned formulary name for states where the issuer's health plan is the benchmark has a set name, e.g., EHB_PLAN. The template assigns a formulary name automatically. (2) Specialty is not available from retail or mail, only specialty provider. There is no place in the template to provide this information, and the assumption made is that in-network retail equals a specialty preferred provider. (3) There is no area to state the number of days' supply at retail and through mail order.	whether or not the prescription drug coverage meets the requirements for QHP certification, such as EHB and non-discrimination standards. The consumers will only see the information about prescription drug coverage that is submitted in the benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage. Drug deductibles are entered in the Plans and Benefits template. The template does not validate successfully until all required data is entered.			

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	(4) There is no area to state if there is a deductible prior to the coinsurance or copayment; (5) It is not possible to validate until all of the information has been entered.				
Plan Management Webinar: USP/Pharmacy	**Q40:** The following errors/issues have not yet been addressed in the prescription drug template: 1. No entry available for pharmacy deductible value and corresponding pharmacy deductible tier administration; 2. No entry available for pharmacy per script maximum (PSM) value and corresponding PSM tier administration; 3. No entry available for pharmacy OOP maximum value and corresponding OOP	**A40:** 1. Prescription Drug deductibles are entered in the Plans and Benefits template. 2. You may enter a Maximum Coinsurance for Specialty Drugs in the Plans and Benefits template for AV calculation purposes. 3. Prescription drug out of pocket maximums are entered in the Plans and Benefits Template.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	maximum tier administration.				
Plan Management Webinar: USP/Pharmacy	**Q41:** How will the prescription drug template link/connect to the Plans and Benefits template since the pharmacy benefit is embedded in the medical plan?	**A41:** On the Plan & Benefits Template under Plan Identifiers, each plan can designate its Formulary ID from the Prescription Drug Template.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: USP/Pharmacy	**Q42:** There is no field to enter a maximum per prescription for coinsurance.	**A42:** You may enter a Maximum Coinsurance for Specialty Drugs in the Plans and Benefits template for AV calculation purposes.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: USP/Pharmacy	**Q43:** The template does not include a Drug Tier Type for "Preferred Specialty." How should these drugs be defined?	**A43:** A maximum of two drug types (one generic type and one brand type) should be selected for each tier. If a tier contains both preferred and non-preferred generics, you may use the Only Select Generics option (the same applies for preferred and non-preferred brands). Please note that consumers will only see the information about prescription drug coverage that is submitted in the benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: USP/Pharmacy	**Q44:** How do we indicate tier 2 coverage for specialty pharmacy?	**A44:** Consumers can see more details about the issuer's prescription drug coverage via the formulary URL. The information can also be provided at the	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		benefit level in the explanation field.			
Plan Management Webinar: USP/Pharmacy	**Q45:** We do not understand how we connect the Prescription Drug Template to the Plans & Benefits Template. The Prescription Drug Template connects to plans by the formulary ID so the cost shares feed into the Plans & Benefits Template, but they are not as detailed as the Prescription Drug Template.	**A45:** Each plan in the Plans & Benefits template must list the formulary ID with which it is associated. The formulary IDs are created in the Prescription Drug template. The Plans & Benefits template does not extract any information from the Prescription Drug template, although you can import the formulary ID from the Prescription Drug template into the Plans & Benefits template. While there will be a validation after submission in the FFM to ensure that plans are associated with valid formulary IDs, you must fill out each template separately. To accommodate the Actuarial Value Calculator, the Plans & Benefits template contains four drug benefit categories that represent a typical four tier drug design available in the market today: Generic Drugs, Preferred Brand Drugs, Non Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly into the Plans & Benefits template. To that end, we recommend ways issuers might translate their cost sharing data from the Prescription Drug template into the Plans & Benefits template, as noted in the section titled "Suggested Coordination of Drug Data Between Templates" in Chapter 10: Instructions for the Plans & Benefits Application Section. For more information on the	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		Prescription Drug template, please see Chapter 12: Instructions for the Prescription Drug Application Section. The consumers will only see the information about prescription drug coverage that is submitted in the Plans & Benefits template. They will be directed to the issuer's website (the URL in the formulary template) for the detailed information about the prescription drug coverage.			
Plan Management Webinar: USP/Pharmacy	**Q46:** In states with an EHB benchmark plan that requires coverage of over the counter (OTC) tobacco cessation products, how does a QHP verify their inclusion in the QHP submission? OTC products do not have RxNorm Concept Unique Identifiers (RxCUIs), which are used to add prescription drugs to a formulary.	**A46:** RxCUIs do exist for a number of OTC products. However, if you cannot find RxCUIs for the specific OTC drugs covered by your plan, you do not need to include them on the Prescription Drug template. To describe in more detail which OTC tobacco products your plan covers, you can use the Explanations fields associated with the drug benefit categories in the Plans & Benefits template. On the Plan Compare website, consumers will see the Explanations from the Plans & Benefits template, along with the formulary URL and the plan brochure URL, if provided.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: USP/Pharmacy	**Q47:** What is the underlying reference file for the HIOS Rx tool so that plans can ensure they are meeting EHB	**A47:** CMS has provided methodology for the drug count service on the CCIIO web site at http://cciio.cms.gov/resources/data/ehb.html. While the EHB Rx Crosswalk is based on version 5 of the United States	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	requirements?	Pharmacopeia (USP) Medicare Model Guidelines, it is not identical to the USP alignment file found at http://www.usp.org/sites/default/files/usp_pdf/EN/healthcareProfessionals/2011-03-11frf-uspmgintegratedfile.xls. The EHB Rx Crosswalk uses RxCUIs from the December 3, 2012 RxNorm release, which you can download at http://download.nlm.nih.gov/umls/kss/rxnorm/RxNorm_full_12032012.zip. To download the file, you need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. Please crosscheck the RxCUIs you are submitting with the December 3, 2012 RxNorm release to ensure they are up-to-date. CMS requests that you include your entire drug list, not just the recognized RxCUIs, when submitting a QHP application.			
Plan Management Webinar: USP/Pharmacy	**Q48:** How do you submit $0 drugs on the pharmacy template? For example, a generic oral contraceptive that is covered at $0 would be submitted with all other	**A48:** If you have no cost sharing for the tier, select Copayment as the cost-sharing type, and set the copayment equal to $0.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	generics (tier 1) – how do you designates these differences ($0 out of pocket vs. true cost share)?				
Plan Management Webinar: USP/Pharmacy	**Q49:** In order to satisfy the drug counts for some categories, intravenous drugs will need to be included. However, these drugs are covered under medical benefits, not pharmacy benefits, and are not obtainable at a retail pharmacy. How should we proceed?	**A49:** As noted in the file rule on EHB at 45 CFR 156.122, a health plan does not provide EHB unless it covers at least the greater of: 1) One drug in every USP category and class; or 2) The same number of prescription drugs in each category and class as the EHB-benchmark plan. If the plan uses the USP Category Class Count Service and uploads a list of all RxCUIs covered under the plan's prescription drug benefit and meets (or exceeds) the benchmark drug counts, the plan will be in compliance with this requirement. If the plan cannot meet the count without including medical drugs in the drug list, we recommend the following steps to submit the QHP application: • For each of the issuer's drug lists, enter all RxCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template, • Use the Formulary-Inadequate Category/Class Count Supporting Documentation and Justification, identified in Chapter 13C of the	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		instructions, to identify how the drug list meets the requirement and submit the RxCUIs associated with the medical drugs for each drug list. Please note that the EHB requirement is a minimum standard, and an issuer should include the entire drug list, not just the recognized RxCUIs, when submitting a QHP application.			
Plan Management Webinar: USP/Pharmacy	**Q11:** Chapter 12 of the Instructions says that "if you have no cost sharing for the tier, select COPAYMENT as the cost-sharing type, and set the copayment equal to $0." We have a two tier benefit where that is setup as follows: Generics are covered at 100% and brands require a 20% coinsurance. In this case, can we submit COINSURANCE 0%, rather than selecting COPAYMENT as directed in the guidance? The new template does	**A11:** Issuers can submit a 0% coinsurance instead of a $0 copayment.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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	validate either way.				
Plan Management Webinar: USP/Pharmacy	**Q12:** What is the preferred way to represent prescription drug cost sharing in an HDHP plan, understanding that once a member satisfies an integrated (med/Rx) deductible, the plan covers 100%? Does the entry in the "Tier Cost Sharing" columns for these HDHP plans assume that the deductible is met so member co-insurance should be input at 0%?	**A12:** Yes, it is assumed that coinsurance applies after the deductible is met.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: USP/Pharmacy	**Q13:** What is the preferred way to represent an HDHP formulary on the QHP prescription drug template understanding that drugs are not in tiers?	**A13:** This should be represented as a formulary with one tier. All drugs in the formulary should be in tier 1.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: USP/Pharmacy	**Q14:** Under the Drug EHB deductible section there are two fields labeled "Default	**A14:** As noted in Chapter 10 of the instructions (https://www.REGTAP.info/reg_library.php), the Default Coinsurance under the Drug EHB Deductible section is only	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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	Coinsurance." Is the default coinsurance field looking for the overall plan coinsurance or a drug coinsurance? If drug coinsurance, our plans have varying Rx coinsurance based on the type of drug (i.e., generic drugs may have one coinsurance whereas brand or specialty drugs may have different coinsurance).	applicable if deductibles are not integrated, and the numerical value for the in-network drug coinsurance should be entered. Specifically, to input a separate drug EHB deductible and coinsurance rate, the user needs to input "No" under the column "Medical & Drug Deductibles Integrated?" As for entering separate coinsurance rates for individual drug tiers, the user can input the different coinsurance rates in the columns of the particular tier level in the Cost Share Variance Template. All of these data elements are used in the calculation of AV and for information on how their inputs are mapped to the AV calculator, please refer to the Chapter 11 instructions (https://www.REGTAP.info/reg_library.php).			
Plan Management Webinar: USP/Pharmacy	**Q15:** How do you submit $0 drugs on the pharmacy template? For example, a generic oral contraceptive that is covered at $0 would be submitted with all other generics (tier 1) – how do you designate these differences ($0 out of pocket vs. true cost share)?	**A15:** Issuers can describe any cost sharing features that do not directly fit into the Prescription Drug Template in the Explanations field of the Plans & Benefits Template. Issuers should complete cost sharing fields for the most typical/most utilized circumstance. Preventive services under the ACA must be covered without the consumer having to pay a copayment or co-insurance or meet the deductible.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
(HHS/CCIIO; Labor; Treasury/IRS)

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Plan Management Webinar: USP/Pharmacy	**Q16:** Some of our plans have 4-tier drug copays. At the end of the template in the cost share variances sheet there are columns for "Off Label Prescription Drugs" and "Prescription Drugs Other." Our practice is that we do not consider whether a drug is "off label" or not - it always gets the copay of the tier it happens to land in. Since there are four different copays depending on the tier and we can only enter one, what do we enter here?	**A16:** Regarding filling in cost sharing, these two fields are not associated with the AV Calculator (only Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs are associated). For cost sharing, you can use the one of the drug tiers and use the Explanations to indicate that the cost sharing depends on the tier. Note: this information will not be displayed on Plan Compare, so consumers will not see the cost sharing that you enter.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: USP/Pharmacy	**Q15:** If there is more than one RXCUI for a particular drug, which RXCUI should be included for the drug list to be compatible with the USP Category Class Count Service in HIOS?	**A15:** The USP Category Class Count Service is provided to assist issuers in complying with the essential health benefits (EHB) prescription drug benefit policy. Per 45 CFR 156.122, this policy requires that every EHB plan covers at least the greater of: (i) one prescription drug in every United States Pharmacopeia (USP) category and class; or (ii) the same number of prescription drugs in each category and class as the	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		EHB-benchmark plan. However, meeting these EHB-required prescription drug coverage levels is a minimum requirement and issuers are permitted to exceed this requirement. Please refer to the EHB final rule (http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf) for further information on the EHB benchmark standard and prescription drug policy. A drug list should include all drugs (RXCUIs) the issuer intends to cover under its prescription drug plan, which means issuers should not leave out the unrecognized RxCUIs from the drug list. Please note that only the ones that are recognized by the EHB Rx Crosswalk will be considered for EHB compliance. The EHB Rx Crosswalk contains only 5,306 RxCUIs and 916 chemically distinct drugs. There are many more valid RxCUIs in the RxNorm database. Therefore, almost any drug list submitted to the USP Category Class Drug Count Service will contain some unrecognizable RxCUIs. As long as you meet the EHB drug count standard for your State, you can ignore the unrecognized RxCUIs and include them in your drug list.			
Plan Management Webinar: USP/Pharmacy	**Q16:** What types of RxCUIs are included in the EHB Rx Crosswalk?	**A16:** Use the December 3, 2012, full monthly release of RxNorm to find a list of valid RxCUIs, which should have one of the following term types (TTYs):	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		semantic branded drug (SBD), semantic clinical drug (SCD), branded pack (BPCK), or generic pack (GPCK).			
Plan Management Webinar: USP/Pharmacy	**Q17:** What does the error "unrecognized RXCUIs" mean and why are they "unrecognized"?	**A17:** Unrecognized RXCUIs are RxCUIs with valid formats (8 digits or less) that are not included in the EHB Rx Crosswalk. As noted above, the Count Service only recognizes 5,306 RxCUIs and 916 chemically distinct drugs. There are many more valid RxCUIs in the RxNorm database. Therefore, almost any drug list submitted to the Count Service will contain some unrecognizable RxCUIs. Plans must meet the prescription drug EHB standards, described in 45 CFR 156.122, but plans may also continue to cover unrecognized drugs that are not counted towards EHB compliance.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: USP/Pharmacy	**Q18:** Are there any over-the-counter (OTC) drugs included in the EHB drug counts?	**A18:** A manual review was performed on RxCUIs that were identified as OTC drugs in the RxNorm database. RxCUIs that were confirmed as OTC drugs were removed from the EHB Rx Crosswalk, so those OTC drugs were not included as part of the benchmark drug counts and will not be counted in the USP Category Class Count Service. However, plans may continue to cover OTC drugs.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: USP/Pharmacy	**Q19:** Does the USP Category Class Count Service report categories and	**A19:** The "Category Class Count Report" returned by the USP Category Class Count Service only includes category and class combinations in	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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	classes with no drugs?	which the uploaded drug list has at least one drug. If the uploaded drug list does not include any drugs in a particular category and class combination, the category and class will not be included in the "Category Class Count Report."			
Plan Management Webinar: USP/Pharmacy	**Q20:** How can an issuer determine if its drug list meets the benchmark count?	**A20:** 1. Use the December 3, 2012, full monthly release of RxNorm to find a list of valid RxCUIs. Download the RxNorm release at http://download.nlm.nih.gov/umls/kss/rxnorm/RxNorm_full_12032012.zip. To download the file, you need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. 2.Upload the drug list's RxCUIs into the USP Category Class Count Service. 3.Download the "Category Class Count Report" returned by the Count Service. 4.Download your state's "Summary of EHB benefits, limits, and prescription drug coverage" fileat http://cciio.cms.gov/resources/data/ehb.html. This document includes each state's benchmark plan drug count by category and class. Compare these	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		benchmark drug counts to your drug list's counts in the "Category Class Count Report." The drug list must include at least the greater of: 1) One drug in every United States Pharmacopeia (USP) category and class; or 2) The same number of prescription drugs in each category and class as the EHB-benchmark plan, per 45 CFR 156.122.			
Plan Management Webinar: USP/Pharmacy	**Q21:** Should Loperamide be included in the EHB Rx Crosswalk?	**A21:** Based on issuer input, CMS has noted an error in the USP Category Count Service. The brand name RxCUI for Loperamide 2mg was mistakenly included in the EHB Rx Crosswalk. Loperamide, as the distinct chemical ingredient, should not have been included on the EHB Rx Crosswalk in brand form because it has an Over the Counter (OTC) equivalent. If issuers have problems with meeting the Gastrointestinal Agents Category, Other class due to this error, please follow the steps that are listed below: For each of the issuer's drug lists, enter all RxCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template, Use the Formulary-Inadequate Category/Class Count Supporting Documentation and Justification, identified in Chapter 13C of the QHP Application instructions manual, to identify reasons for an inadequate drug count in a specific	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		category or class.			
Plan Management Webinar: USP/Pharmacy	**Q38:** Can HHS provide a crosswalk table that maps the RxCUI to the class and counts?	**A38:** We do not intend to release the crosswalk table. We note, however, that the RxCUIs are drawn from the December 3, 2012, RxNorm release, which you can download at http://download.nlm.nih.gov/umls/kss/rxnorm/RxNorm_full_12032012.zip . To download the file, you need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. The EHB Rx Crosswalk contains only 5,306 RxCUIs and 916 chemically distinct drugs. There are many more valid RxCUIs in the RxNorm database. Therefore, almost any drug list submitted to the USP Category Class Service will contain some unrecognizable RxCUIs. As long as you meet the EHB drug count standard for your State, you can ignore the list of unrecognized RxCUIs.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: USP/Pharmacy	**Q39:** What is considered "Off Label Prescription Drugs"?	**A39:** Off-label prescription drugs are FDA-approved prescription drugs that are prescribed for indications other than those stated in the labeling approved by the FDA.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: USP/Pharmacy	**Q40:** What tier should issuers assign for items that are	**A40:** The number of tiers in the prescription drug formulary template is limited to seven. For drugs with $0 cost	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	mandated to be provided at a $0 cost share, when Tiers 1 – 7 are already utilized to list therapies which include a member cost share?	sharing, you may add those to the lowest cost sharing tier and indicate in the Plans and Benefits template that certain drugs in that tier have no cost sharing.			
Plan Management Webinar: USP/Pharmacy	**Q41:** Since drugs covered under medical are not captured in the pharmacy drug list, how will these medical drugs be included to determine compliance with EHB? Will they need to be reported separately?	**A41:** Issuers will need to submit a list of the medical drugs covered as they would any other supporting documentation to justify any exception to any field in the Plans and Benefits template, i.e., upload a MS Word or PDF document into HIOS. Please note that HHS still advises issuers to make use of the drug count tool in HIOS to verify that the RxCUIs in their list of "medical drugs" satisfy the category and class counts for the issuer's State's benchmark plan (as well as having at least 1 drug in each category and class).	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: USP/Pharmacy	**Q42:** Will issuers be able to update their drug list throughout the year and is this allowed for plans offered on the Exchange? Are issuers required to submit notice of adjustments made after the submission of the QHP application?	**A42:** In States with a Federally-Facilitated Exchange, issuers submit their drug list once during the annual QHP certification period. HHS understands that drug lists are dynamic and updated often. Issuers are permitted to change their drug lists throughout the year as long as they remain compliant with the EHB policy (45 CFR 156.122) requiring that every drug list includes at the least the greater of (1) one drug in every USP category and class or (2) the same number of prescription drugs in	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		each category and class as the EHB state benchmark plan. Issuers are not required to submit updated drug lists to HHS throughout the year; however, policies in States with a State-based or Partnership Exchange may differ.			
Plan Management Webinar: USP/Pharmacy	**Q43:** If a benchmark plan does not cover any drugs in a specific Rx category, do issuers have to cover at least one drug in that category?	**A43:** The policy at 45 CFR 156.122 states that a formulary must include the greater of one drug in each USP category and class or the same number in each category and class as the State benchmark. Therefore if the State's benchmark drug list does not cover a drug in a particular USP category and class, then the issuer is responsible for covering one drug in that USP category and class.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: USP/Pharmacy	**Q44:** If a plan has drugs offered through the medical benefit that it wants to count -- for reasons of compliance with EHB policy -- the minimum number of drugs per category/class, how should that be submitted to HHS?	**A44:** If the plan uses the USP Category Class Count Service and uploads a list of all RxCUIs covered under the plan's prescription drug benefit and meets (or goes above) the benchmark drug counts, the plan will be in compliance with this requirement. However, if the plan cannot meet the count unless it includes medical drugs in the drug list, HHS recommends the following steps to submit the QHP application - • For each of the issuer's drug lists, enter all RxCUIs covered under the plan's prescription drug benefit in the Prescription Drug Template, • Use the Formulary-Inadequate Category/Class Count Supporting Documentation and	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		Justification, identified in Chapter 13C of the instructions, to identify how the drug list meets the requirement and submit the RxCUIs associated with the medical drugs for each drug list.			
Plan Management Webinar: AV Calculator	**Q53:** How does the AV Calculator account for the dental and vision benefits and their cost sharing inputs?	**A53:** The dental and vision benefits are accounted for in AV Calculator. These specific services do not generally amount to a material difference in the actuarial value calculation. Please refer to the AV Calculator methodology for further information on the calculator's underlying logic, development, and usage. http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: AV Calculator	**Q54:** How does the AV Calculator account for Health Savings Accounts (HSAs)?	**A54:** The AV Calculator allows for an employer's contribution to an HSA to be taken into account for the AV determination. This is consistent with our regulation at 45 CFR §156.135(c). The EHB final rule is available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf.	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf
Plan Management Webinar: AV Calculator	**Q55:** Do issuers have to enter health savings account (HSA) contributions when calculating the AV of a plan? What happens if issuers do not know what the contribution is going to be?	**A55:** The amount of the employer contribution to the HSA has to be known to the issuer at the time of purchase. If issuers are not able to confirm the health savings account when using the AV Calculator, it cannot be included in the plan. When the issuer does not know the actual value of the HSA contribution, as long as the AV is within the de minimis range, it is	FAQ April 16, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP040213_FAQs4_041613.pdf

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		acceptable. The AV Calculator is available on the CCIIO website at http://cciio.cms.gov/resources/files/av-calculator-final.xlsm.			
Plan Management Webinar: AV Calculator	**Q1:** Is any other supporting documentation (e.g., screenshots or other display of how we entered inputs into the AV Calculator) expected to be submitted when we provide the AV of a given plan design, or are we providing only the actual AV figures, along with justification for any modifications?	**A1:** Additional documentation is not required. For the FFM, the only requirement for general plan designs is inputting the plan designs into the Plans and Benefits Template and using the AV calculator within the template to determine the AV of the plan. Additional information is needed only if 1) for some reason there is a discrepancy (outside the de minimus range) between the AV determined by the template and the AV determined directly by the calculator; or 2) you are submitting a unique plan design utilizing non-AV Calculator data for which you will need to provide supplemental information. For more information on exceptions to using the AV Calculator, see 45 CFR 156.135(b).	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: AV Calculator	**Q2:** There have been several instances where the AV calculated by the benefits template does not match for the same benefit from the AV Calculator. In some cases, the difference is quite a	**A2:** Chapter 11 of the instructions is posted on the REGTAP portal and on SERFF and provides detailed information on how this process works and how the fields are mapped from the Plans and Benefits Template to run the AV Calculator. Issuers are encouraged to assess the AV of a given plan design by first using the stand-alone AV Calculator. After	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	bit; in all cases they failed the metal test in the template but not in the calculator.	completion of the Plans and Benefits Template, the AV obtained from the Template should match the value obtained via the stand-alone AV Calculator. • If the AVs are not matching, the issuer should first ensure that it correctly filled out the Template per the instructions in Chapter 11. • If the issuer is still having difficulty matching AVs, you can contact the Help Desk at: CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515. Please submit a screen shot of the AV Calculator and a copy of the Plans and Benefits template with your completed data for that given plan, which will help us identify the problem. • If at the end of this process the issuer is still unable to obtain an AV from the Plans and Benefits Template that matches what it obtains via the stand-alone AV Calculator, then there is an option mentioned in the Chapter 11 instructions that would allow a plan to submit their plan as a unique plan design, complete the Issuer Actuarial Value data field, and upload a screen shot of the AV Calculator with the obtained value as the supporting documentation. Please see these instructions for more details. Also			

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		please note that in this situation, designating your plan as a unique plan design will not require submission of an actuarial certification pursuant to 45 CFR 156.135(b) and will cause the plan to be considered unique for review purposes. • We also revised the Plan and Benefits Add-In File on April 11 to address discrepancies related to the AV calculation that some issuers were encountering. This updated file is now available for download at the CMSzONE online repository at https://zone.cms.gov/ to those users who are part of the Issuer Community. The same templates have also been made available by the NAIC on their website at http://www.serff.com/plan_management_data_templates.htm. If you encountered a discrepancy before April 11, please try again.			
Plan Management Webinar: AV Calculator	**Q3:** What guidance is there on selecting metal tiers for cost share reduction plans in the AV calculator and the Plans and Benefits Template?	**A3:** Per the AV Calculator Methodology that was published with the essential health benefits final rule, we provided guidance on which metal tier should be chosen to align with the expected utilization for each plan variation. Household Income: 100-150% of FPL Silver Plan Variation AV: 94% Desired Metal Tier: Platinum	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		Household Income: 150-200% of FPL Silver Plan Variation AV: 87% Desired Metal Tier: Gold Household Income: 200-250% of FPL Silver Plan Variation AV: 73% Desired Metal Tier: Silver Specifically, when inputting a CSR Plan Design into the AV calculator, the user needs to check the box "Indicate If Plan Meets CSR Standard" and select the appropriate metal tier from the list above. For the Plans and Benefits template, the template will automatically send the correct Desired Metal Tier to calculate the AV. For additional information, please refer the AV calculator methodology document posted at: http://cciio.cms.gov/resources/files/av-calculator-methodology.pdf or the Chapter 10 Instruction on Plans and Benefits Template at: https://www.regtap.info/uploads/library/Chapter_10_Plan_Benefit_Template_Instructions_Version3.pdf			
Plan Management Webinar: AV Calculator	**Q22:** Do issuers have to submit a completed AV Calculator as part of QHP certification?	**A22:** The Plans and Benefits Template that is used to certify QHPs is integrated with the AV Calculator. Therefore, if the issuer is using the Plans and Benefits Template, the issuer will need to download the AV Calculator because	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		the Plans and Benefits Template will require the user to open the AV Calculator into the Plans and Benefit Template. Then, the Plans and Benefits Template will automatically map the fields to the AV Calculator to produce the plan's AV. Additional information on this process is available in Chapter 11 the Plans and Benefits Instructions at: http://www.serff.com/documents/plan_management_data_instructions_ch11.pdf. Issuers should defer to their state regulator regarding the submission of a completed AV Calculator.			
Plan Management Webinar: Attestations	**Q6:** What is the CMS guideline for significant change to the organizational chart? Who in HHS do we need to inform of the significant change? If there is not a specific person, what group within HHS do we need to inform?	**A6:** What is considered a significant change varies for each organization depending on its organizational structure, the size of the organization, and the chain of command for reporting operational issues. Changes that could be reasonably foreseen to affect the day-to-day operations of the QHP issuer in an FFE or to compromise the ability of the QHP issuer to maintain compliance with Federal standards should be reported to the FFE. Issuers operating QHPs in the FFE will be assigned a CMS Account Manager as their primary point of contact, and are encouraged to discuss significant organizational changes with that person.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Attestations	**Q7:** How should we respond to the Stand	**A7:** In the Stand Alone Dental Attestation section, selecting "Yes"	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	Alone Dental Attestation if we are not offering Stand-Alone Dental plans? What happens to the 3 sub-questions in this case?	indicates that either: • You are attesting to all the statements in the section, OR • You do not offer Stand Alone Dental plans.			
Plan Management Webinar: Attestations	**Q4:** In the attestations section, what does it mean that we will "accept" the total premium breakdown from the Exchange?	**A4:** The FFE will use the rate tables submitted by QHP issuers during QHP certification to determine the total premium amount (and associated premium breakdown) for the enrollment group. This breakdown is captured in the 2750 loop of the 834 transaction. If QHP issuers do not believe that the Exchange arrived at the correct total premium amount (and associated premium breakdown) for the enrollment group, there will be a process established to resolve any discrepancies.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: Benefits and Services Area	**Q8:** For facility out-of-network fees, coinsurance pays 20% out-of-state and 50% in state. When completing the cost-sharing variation, do we choose the most likely scenario, which would be 20% coinsurance out-of-state in this case? Or do we report the higher deductible	**A8:** We recommend that the issuer fill out the copay and/or coinsurance that would be most typical for most enrollees (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate other cost sharing in other scenarios outside of the most common one already entered into the worksheet.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	since it is the worst case, but less likely scenario?				
Plan Management Webinar: Benefits and Services Area	**Q9:** Are coverage mandates that impose pharmaceutical benefits into medical plans, for example, state mandates that require coverage of oral chemotherapy, considered to be subject to state compensation?	**A9:** Any state-imposed requirement on a medical benefit for which an issuer is required to cover a particular benefit is considered a mandate. If that mandate was enacted after 12/31/2011, then the state would be required to defray the cost. However, per the prescription drug EHB policy described in 45 CFR 156.122, every drug list must cover the greater of: i) one drug in each USP category and class or, ii) the same number of prescription drugs in each category and class as the EHB-benchmark plan. This policy is a minimum requirement and plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB. Therefore, state-mandates related to the coverage of specific drugs do not exceed EHB.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q10:** Will plans be allowed to update their marketing name prior to plan preview in August? Many companies have not fully identified their marketing name and would like to include a placeholder name in the interim. We	**A10:** Issuers will be able to correct this on the Administrative Template during resubmission or Plan Preview periods. In version 1.3 of the add-in file, the Update Cost Share Variances macro will now automatically update any changes to the Plan Marketing Name on the Benefits tab to the Cost Share Variances tab.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	are having trouble doing this in the template—when we update the "Plan Marketing Name" on the benefits tab and complete an update for the cost-share variance tab, the plan marketing name of the CSR tab does not change.				
Plan Management Webinar: Benefits and Services Area	**Q11:** Excel generates a warning that the maximum out-of-pocket (MOOP) exceeds the IRS out of pocket max for 2013 ($6,250 and $12,500 family). We've have been directed that the government amount is $6400.	**A11:** Since the IRS limits for 2014 have not been established, the 2013 limits were used to alert you that you may have exceeded the maximum. Please check the QHP Application Instructions, Chapter 10, for more detailed instructions.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q12:** For a small group market QHP issuer using more than one service provider to administer benefits subject to the maximum out-of-pocket (MOOP), the final 2014 Letter to	**A12:** The Plans and Benefits template allows for separate medical and drug out of pocket maximum. Regarding the AV Calculator, it is true that an error will be returned if the sum of the separate medical and drug out of pocket maximum exceeds $6,500. In that case, we recommend that the issuer submit this plan as a "unique plan design" which will allow the template to pass	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	Issuers states that the MOOP limitations will be met if the QHP complies with MOOP for major medical coverage and MOOP on coverage not consisting solely of major medical does not exceed the dollar amounts set forth in the Letter ($6,400 for self-only and $12,800 for family). However, the QHP submission template does not appear to accept this separate $6400 MOOP amount for prescription drug, pediatric dental, or pediatric vision, and results in a validation error.	out of pocket maximum validations and bypass the AV Calculator error message. As unique plan designs incompatible with the AV Calculator, issuers will be required to submit an actuarial certification.			
Plan Management Webinar: Benefits and Services Area	**Q13:** The PA Benefit File includes adult vision as a required covered benefit; however, per the EHB final rule adult vision is not EHB, per 45 CFR 156.110. How should we	**A13:** If a QHP does not cover adult vision, please select “not covered” and note the EHB variance reason as “other law/reg."	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	handle this?				
Plan Management Webinar: Benefits and Services Area	**Q14:** The Plan and Benefits template does not appear to allow the application of 3 cost shares (Deductible + Coinsurance + Copay) on select services within a plan design.	**A14:** Select services on the Plan and Benefits template will not allow both a coinsurance and copay. For example, the generic drug data field cannot accept both because the AV Calculator requires one or the other. Per the user guide to the AV Calculator, the prescription drug benefits do not allow for both a copay and coinsurance for the same drug tier. When you input the plan design into either the Template or the AV Calculator, we recommend that you use your best actuarial determination to align your benefits to the four drug tiers. We recommend that you take the highest cost-sharing rate where possible. If you feel that this approach results in a material difference for AV, there is the option for issuers to submit plans as unique plan design. In addition, the AV Calculator does not include the ability to input copays for outpatient surgery because the data that supports the AV Calculator does not allow for copays for outpatient surgery. Instead, HHS recommends that plans estimate the copay's percentage of total cost for the benefit and input the remaining percentage into the calculator as coinsurance.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q15:** The Plans and Benefits template does not appear to	**A15:** When completing the cost sharing for the specific benefits, we recommend that the issuer fill out the copay and/or	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	allow the application of a copay for a select number of visits before a Deductible + Coinsurance applies.	coinsurance that would be most typical for most enrollees within the confines of the data entry permitted by the template. (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate cost sharing in other scenarios outside of the most common one already entered into the worksheet.			
Plan Management Webinar: Benefits and Services Area	**Q16:** How do we input cost share methods other than simple copay or coinsurance? (e.g., Greater of/Lesser of; Copayment/Coinsurance; $1000 a day for days 1-3, then covered at a copay/ coinsurance)	**A16:** When completing the cost sharing for the specific benefits, we recommend the issuer should fill out the copay and/or coinsurance that would be most typical for most enrollees within the confines of the data entry permitted by the template. (e.g., highest utilized). In the "Explanations" field, the issuer should add appropriate and brief detail to communicate other cost sharing in other scenarios outside of the most common one already entered into the worksheet.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q17:** Will HHS be generating an SBC?	**A17:** The FFM is not generating SBCs.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q18:** We are trying to enter an HSA-compatible plan at one metal level, but not at any of the other metal levels. When we select “Yes” or” No” for the “Subject to	**A18:** All of the data elements in the benefit package section of the template apply to all plans. You can create additional benefit packages within the template with the Create New Benefits Package macro. You may copy past the cells from your initial benefit package, and then make the changes that apply to your new package. There is no	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	Deductible" question, the response applies to all plans on the template. Is it possible to enter an HSA at one metal level and then PPOs at the other levels, on the same template? Is it possible to only enter one metal level on the template, and not all required metal levels (Silver and Gold)?	requirement that all plans associated with a product have the same benefit package.			
Plan Management Webinar: Benefits and Services Area	**Q19:** There is a problem with the Component Numbers column in the Plan Benefit Add-in. The new product numbers that are viewable include some repetition and do not correspond to the product numbers that appear on the HIOS template successfully uploaded.	**A19:** Standard Component Plan IDs must be entered in the Plans and Benefits template by the issuer. There is no macro or functionality in the Plans and Benefits Add-in file to support this. If you are seeing this issue in the Excel version of your .xml upload that you got from SERFF or the Benefits and Service Area module in HIOS, please contact the Help Desk. They will need a copy of your Excel template, your .xml upload, and the Excel file that you downloaded after successful validation.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q20:** Should the partial county justification also be used to enter	**A20:** The service area template only requires that zip codes be entered when a county is not fully covered. If the partial zip code is part of a complete	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	information on partial zip codes?	county being covered, no zip code information is required. If a zip code extends from a full county into a partial county, the zip code would only be entered on the partial county list. In this case, a partial county justification is required. If the zip code extends from one partial county to another, the issuer should enter the zip code under both counties. Partial county justifications will be required for both partial counties.			
Plan Management Webinar: Benefits and Services Area	**Q21:** When creating a stand-alone dental plan, no functionality appears to change in the EHB section. The EHBs do not apply and most of the benefit information is geared toward the medical products.	**A21:** The Plans and Benefits template will be updated to simplify the data submission for stand-alone dental by approximately May 15, 2015. A testing version will be made available prior to that. There will be a later submission window to accommodate stand-alone dental applications.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q22:** Do dental plans need to offer child-only plans? How should the field regarding child-only be answered in the plan and benefits template?	**A22:** As stated in the Exchange final rule released March 27, 2012, stand-alone dental plans need to comply with the requirement to offer child-only coverage. The final rule explains that 45 CFR 155.1065(a)(3) would apply the standard of 45 CFR 156.200(c)(2) to offer a child-only plan to stand-alone dental plans certified to be offered through the Exchange. Please see number 14 and 15 on page 10-8 in the instructions for filling out the child only	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		field in the plan and benefits template, found here: http://www.serff.com/documents/plan_management_data_instructions_ch10.pdf. If an Issuer assures that child enrollees would be treated equally under a QHP as they would be under a child-only plan, such that there would be no substantive difference between having a child-only plan and issuing child-only policies under the QHP (i.e., same premium rating), then the issuer does not need to file a separate child-only plan. Separate child-only plans are not required for the Federally-facilitated Exchange (FFE) as long as the QHP indicates it will accept child-only enrollees. Also, note that the plan and benefits template for stand-alone dental plans will not be finalized until May, as described in the final Letter to Issuers available at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf.			
Plan Management Webinar: Benefits and Services Area	**Q23:** For all of the specific benefits throughout the Benefits template, you must enter both a copayment and coinsurance, although you usually have one and not the other. The template	**A23:** In our system, “no charge” and “0” are the same.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	allows you to enter "no charge" or a dollar amount or percentage. The CMS instructions indicate to enter "no charge" when there is no copayment or coinsurance, but we are concerned about how that translates to the consumer.				
Plan Management Webinar: Benefits and Services Area	**Q24:** There is conflicting guidance and instructions for filing as to whether and how to put a copay on the three primary care visits for the catastrophic plans.	**A24:** The issuer is permitted to impose cost sharing in connection with the three primary care visits as along as permitted by other applicable law (e.g., the preventive services provisions of PHS Act section 2713).	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q25:** On the Benefit template, should the coinsurance reflect what the member will pay or what the issuer will pay?	**A25:** On the Plans and Benefits template, the coinsurance amount should be the amount that the member will pay. The Check AV Calculator Validation macro will convert that to the amount that the issuer will pay for the AV Calculator.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q26:** For the Specialists Requiring Referrals and Plan Exclusions fields within the Plan & Benefit Template,	**A26:** Specialist Requiring A Referral is required when the Is a Referral Required for Specialist? field is "yes." Plan Level Exclusions is required when there are plan level exclusions. There are no automated checks for this. The	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	are these fields truly optional and is there a character limitation?	template will accept values up to the Excel limit. However, the following fields have size limits in the system: • Plan Marketing Name: 255 characters • Plan Level Exclusions: 2000 characters • Out of Country Coverage Description: 2000 characters • Out of Service Area Coverage Description: 2000 characters • Exclusions: 2000 characters • Explanation: 2000 characters			
Plan Management Webinar: Benefits and Services Area	**Q27:** Is Limited Cost Sharing Plan Variation - Estimated Advanced Payment truly an optional field?	**A27:** Leaving column Q, "Limited Cost Sharing Plan Variation – Estimated Advanced Payment" blank indicates that the issuer does not request advance payments for the value of cost-sharing reductions provided under the limited cost sharing plan variation for the QHP associated with the benefit template. As indicated in the HHS Notice of Benefit and Payment Parameters (available at: http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf) QHP issuers may, but are not required to, estimate the value of cost-sharing reductions that they will provide through their limited cost sharing plan variation if they wish to receive advance payments from HHS. Issuers that choose not to submit such estimates by leaving column Q blank must still provide the cost-sharing reductions to enrollees in the limited cost sharing plan variation, and will be reimbursed by	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		HHS at the close of the benefit year. More information on issuer options with respect to such estimates is included on page 15495 at the link above.			
Plan Management Webinar: Benefits and Services Area	**Q28:** Under the Copay and Coinsurance sections, we actually need options for both "not applicable" and "not covered." Being able to specify a benefit as not covered is consistent with what we do for SBC, and is more communicative to a consumer.	**A28:** If a benefit is not covered, the value for Is This Benefit Covered? On the benefits package worksheet should be Not Covered. Only covered benefits copy to the Cost Share Variance worksheet. If a benefit is covered in-network only, enter 100% for Out Of Network Coinsurance.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Benefits and Services Area	**Q29:** Can CMS provide additional guidance on service area requirements? Additionally, is it necessary to spell out pharmacy as part of the service area templates if the issuer is using a vendor to supply pharmacy benefits?	**A29:** According to the final rule "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers" at 45 CFR 155.1055, the service area of a QHP must cover a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. The service area of a QHP must be established without regard to	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		racial, ethnic, language, or health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high-utilizing, high-cost, or medically-underserved populations. The service area of a QHP is the geographic area in which an enrollee could access services and be covered under that particular QHP. To provide service area information in the QHP Application, the applicant must complete the Service Area template. The template requires the applicant to identify the service areas it will utilize for its QHPs. The applicant should input the county information for each service area that is covered by a QHP. Even if the issuer uses a contracted vendor for pharmacy services, the issuer is responsible for ensuring that pharmacy benefits are available in the issuer's proposed service area.			
Plan Management Webinar: Benefits and Services Area	**Q5:** If we are participating in the risk corridor program for both on and off Exchange products, do we report our off Exchange products on the benefit template? The Plans and Benefits template does not	**A5:** The benefits template for the QHP application process are to be used for the Exchange-offered products and plans. For Exchange products that are offered off the Exchange, we will collect data needed for the risk corridor program at a later date. It should not be submitted as part of the QHP application process.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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	appear to allow the application of a copay for a select number of visits before a Deductible + Coinsurance applies.				
Plan Management Webinar: Benefits and Services Area	**Q6:** Are there character limits on the open data fields in the templates? Is there a way to submit additional information in a supporting document?	**A6:** Here are the fields from the Plan and Benefits template that have size limits: 1) Plan Marketing Name – 255 characters 2) Plan Level Exclusions – 2000 characters 3) Out of Country Coverage Description – 2000 characters 4) Out of Service Area Coverage Description – 2000 characters 5) Exclusions – 2000 characters 6) Explanation – 2000 characters Yes, the benefits module has a "supporting documents" upload feature that supports the submission of additional information for a QHP application. Some of these supporting documents may include justifications explaining in more detail how a given QHP benefit design meets application requirements (e.g., actuarial certification for actuarial value). Please see our Chapter 10 and 13 instructions for more information on supporting documents	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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		and justifications. We also want to highlight that plans may submit a URL for their plan brochures as well as their Summary of Benefits & Coverage via the Plans and Benefits template. These links will be provided to consumers so that they can obtain more detailed information on a given QHP if they would like it during the shopping process.			
Plan Management Webinar: Benefits and Services Area	**Q7:** How would the employer premium be divided among employees if an employer chooses to use "composite rate/average rate" method, but one simple one for the "member rate" which determines the employee contribution based on the employee and his or her dependents' age and tobacco use. Can an employer inadvertently violate the ADEA for using this method?	**A7:** There is a potential for ADEA violations if an employer contributes the same dollar amount to each employee and employees must pay a premium that varies by age. To overcome this problem, the FF-SHOP standard contribution method, as finalized at 45 CFR 155.705(b)(11)(ii), establishes a method by which the employer can contribute in a standardized, non-discriminatory way. The requirement to use this method to determine employer contributions only exists on FF-SHOPs. We do not believe that either the proposed rule or the final rule involves the QHP issuer in employer decisions about the employer contribution toward the premium. The FF–SHOP standard contribution method, as proposed and finalized, does establish a method by which the employer can contribute in a standardized, non-discriminatory way. The QHP issuer is not involved in the FF–SHOP [contribution] policy nor is the issuer involved in employer	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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		decisions about the allocation of premium between employer and employee.			
Plan Management Webinar: Benefits and Services Area	**Q8:** Do we need to supply the product name in the templates to display on healthcare.gov?	**A8:** For the Federally Facilitated Marketplace, the product name will not display to consumers, only the Plan Marketing Name.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: Benefits and Services Area	**Q8:** If an issuer's service area is the entire State, and the issuer wants to offer a plan that is only available in a certain part of the State, would that be another service area?	**A8:** Yes. Each QHP must be associated with a single service area ID. If an issuer is applying to offer three QHPs, one available in service area A, a second available in service area B, and a third available across A and B, then the issuer should define a service area C by listing all of the counties included in both A and B, and use service area C for the third QHP. Having an entire State service area for one QHP does not preclude also having one or more smaller service areas defined as a county or group of counties within the State for other QHPs.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Benefits and Services Area	**Q9:** Do the rating areas and service areas have to match? Will the service area be defined by the given State similar to the Rating Areas?	**A9:** There is no FFE requirement that Service Area and Rating Areas have to match. See 45 CFR 147.102(b) and the preamble discussion in the final market rules at 78 FR 13410. States may have specific requirements related to Service Area, and issuers in the FFE are responsible for complying with these State requirements. Issuers will identify their service areas using the Service Area template. See the Chapter 9 of the	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		Instructions for more information on filling out the Service Area template.			
Plan Management Webinar: Benefits and Services Area	**Q10:** If an issuer plans to offer individual coverage on the Exchange in 10 counties in a single State, will the 10 counties be considered 1 service area or 10 service areas?	**A10:** Each QHP must be associated with a single service area ID. In this example, the ten counties would make up the QHP's single service area.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: Benefits and Services Area	**Q46:** Are issuers required to have their service area cover the entire geographic area of their network?	**A46:** Service areas in FFE States must satisfy 45 CFR 155.1055 of the Establishment of Exchanges and Qualified Health Plans final rule, which requires: "(1) the service area of a QHP to cover a minimum geographical area that is at least the entire geographic area of a county, and (2) the service area to be established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations." As noted in the QHP Application Instructions, in most situations, the FFE will only approve service areas covering full counties. In the rare case in which the issuer is requesting to cover a service area containing a partial county, the issuer must provide the included ZIP codes, a justification for why the entire	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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		county will not be served, and a detailed description that illustrates why the request is not discriminatory. Each QHP offered on the FFE must be approved or deemed for sale in the State (as applicable under state law) before final certification. Upon application, the issuer will need to attest to adhering to all applicable State and Federal law. This would include compliance with service areas defined by the State. There is no requirement that the service area cover the entire geographic area of the issuer's network.			
Plan Management Webinar: Benefits and Services Area	**Q47:** If a health plan will be offering QHPs in certain cities and counties in a State, instead of the entire State, do issuers have to designate and name a unique service area ID for each city and county in the drop down box of the service area template? Or, would an issuer designate and name one service area and list all of the cities from the drop down box that are included in the	**A47:** As noted in the QHP Application Instructions, within States where an issuer is licensed, they may offer plans in defined service areas which can include an entire State, certain counties within States, and under limited circumstances partial counties within a State. The template requires that an issuer's service area ID be generated (not user-assigned). Each plan must be associated with a single Service Area ID, so issuers should create enough service area ID's to cover each unique combination of counties for which it intends to offer a QHP. A single Service Area ID can be used for multiple plans. Application Instructions are also posted on the REGTAP website at https://www.REGTAP.info/.	FAQ May 3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	service area?				
Plan Management Webinar: Business Rules	**Q30:** With regard to the business rules for age on effective date in SHOP, does this refer to the date of employer group policy issuance/renewal or date of the individual employee's policy issuance renewal?	**A30:** Age is determined based on effective date of coverage, not age at time of contract finalization with the employer.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: Business Rules	**Q31:** Column G asks for "What are the maximum number of children used to quote a child-only contract?" For SHOP business, we will not offer a child-only SHOP contract. Coverage will be offered only as a part of employee coverage. The field is required and will only allow "1," "2," or "3 or more" as an option. How do we enter this for SHOP?	**A31:** The Affordable Care Act requires an issuer offering a QHP at any level of coverage pursuant to section 1302(d) of the ACA, to also offer a child-only plan. If an Issuer assures that child enrollees would be treated equally under a QHP as he or she would be under a child-only plan, such that there would be no substantive difference between having a child-only plan and issuing child-only policies under the QHP (i.e., same premium rating), then the Issuer does not need to file a separate child-only plan. Separate child-only plans are not required for the Federally-facilitated Exchange (FFE) as long as the QHP indicates it will accept child-only enrollees. In the FF-SHOP, children may only be added to an employee policy if the employee also enrolls. There may be instances when employees under the age of 21 enroll in	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		an employee-only plan. In this instance, this would be considered child-only coverage.			
Plan Management Webinar: Marketing	**Q9:** Will HHS review QHP marketing materials?	**A9:** We do not plan to review marketing materials, as noted in Chapter 3 of the Letter to Issuers on Federally-facilitated and State Partnership Exchanges, released on the CCIIO website on April 5 at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf. In the Letter, we stated, "Because states generally already regulate health plan marketing materials and other documents under state law, CMS does not intend to review QHP marketing materials for compliance with state standards as described at 45 C.F.R. § 156.225. However, to assist consumers in identifying plans that have been certified by an Exchange, we recommend that all marketing materials distributed to enrollees and to potential enrollees, contain the following disclaimer: '[Insert plan's legal or marketing name] is a Qualified Health Plan issuer in the [Health Insurance Marketplace].' A logo for the Health Insurance Marketplace will also be made available for use on marketing materials. Marketing materials should include communications to consumers and enrollees, such as advertising materials, consumer notices, and brochures. We note that consumer-	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf

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		facing materials will refer to the Exchange as the 'Health Insurance Marketplace.'" We also noted that, in addition to complying with state marketing standards that apply to all issuers, QHP issuers must ensure that all marketing products and materials meet the meaningful access standards. Finally, issuers will need to attest as part of the QHP application process that they will market QHPs in accordance with all applicable state laws and regulations and will not employ discriminatory marketing practices in accordance with 45 CFR 156.225.			
Plan Management Webinar: Marketing	**Q10:** Regarding the requirement that all marketing products and materials meet "meaningful access" standards, will HHS provide guidance on these standards?	**A10:** In the final Letter to Issuers, we provided more information on meaningful access standards in the FFE in Chapter 5, Section 6. As noted in the Letter, we intend to provide further information on this in the future.	FAQ April 23, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ6_042313.pdf
Plan Management Webinar: HIOS	**Q82:** How are identifiers from HIOS used (component IDs, plan IDs, etc.) and for which templates?	**A82:** HIOS Product IDs reference a form filing level, and allow us to link benefit packages back to State regulatory oversight. Standard Component IDs identify the specific package of benefits and cost sharing for which a rate can be assigned, and a specific premium can be quoted based on rating rules. Standard Component IDs contain the Issuer and Product IDs with which they are associated. When	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		submitting Benefit Templates, Unified Rate Review Templates, and Rate Table templates, you will need to use Standard Component IDs which allow us to link different information together at the level a consumer will see it. The Business Rules Template (for policy construction and rating rules) can accept either the higher level product IDs, or the lower level Standard Component IDs, depending on the level a company uses to define its rules. HIOS Issuer IDs (which identifies a company operating in a State) are required for all templates, and indicate the high level organization of who is submitting these prospective QHPs for certification.			
Plan Management Webinar: HIOS	**Q83:** If a State is requiring SERFF to submit the QHP application, do issuers still need to work on HIOS in any way? If yes, how? What specifically has to be done on HIOS?	**A83:** There are several instances when a user submitting a QHP Application to a SERFF State will need to utilize HIOS. First, anyone using the CMS/SERFF templates will need to access HIOS to obtain product and plan IDs. If your organization has been selling in the individual or small group markets, then you should have been entering HIOS for the PlanFinder collection associated with HealthCare.gov, and the process is exactly the same. Issuers need to submit basic information on their form filings as “products” which generates product IDs. All QHP submissions must link up to a reported product in HIOS. Once you have submitted that basic information, you can request a block of	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf

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		Standard Component IDs (formerly called plan IDs). There have been trainings, and instructional materials are available both at http://cciio.cms.gov/resources/files/hios-portal-overview-training02252013.pdf as well as the RegTap site. If you have staff who have been reporting for HealthCare.gov, those individuals should be able to walk you through the process. In addition to the above, in Partnership States, HIOS will receive data from SERFF for use in finalizing the QHP Certification process. Issuers who submitted QHP Applications in SERFF will need to interact with HIOS as part of the Plan Preview period (currently estimated August 22-26) as well as to finalize the certification of QHPs at the end of the process to sign agreements with CMS (currently estimated September 5-9). Also, existing filing and submission requirements for other CMS programs still apply, such as the requirements related to providing rate increase submissions under 45 CFR 154.215. If an issuer plans to offer products outside of the Federally Facilitated Marketplace, please follow the rate review filing requirements under 45 CFR 154.220 and contact the State to determine state specific filing requirements. As noted in the Health Insurance Market Rules; Rate Review final rule			

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		[http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf] when making a rate filing submission, all on- and off-Exchange products must file the Part I Unified Rate Review template and Part III Actuarial Memorandum into HIOS. If an issuer is not applying to offer any QHPs in the same risk pool, the Part I Unified Rate Review template and Part III Actuarial Memorandum are due on the timeline set by the state, but before January 1, 2014.			
Plan Management Webinar: HIOS	**Q84:** How do issuers sign up for zONE?	**A84:** The website is https://zone.cms.gov. An issuer will need a CALT User ID and Password to access the site. Once on the site go to the "Issuer Community" and simply click on the "Request Membership" to be made a member which will allow Issuers to access information and documents.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: HIOS	**Q85:** Do issuers need to register one user per carrier or multiply users per carrier to use the new ZONE forum?	**A85:** Each individual Issuer (user) should have its own User ID and Password.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: HIOS	**Q86:** When will the fixed QHP templates be released to SERFF?	**A86:** Templates were released to SERFF and posted to CMS zONE starting on March 18, 2013. Updated templates are posted to CMS zONE and released to SERFF as they become available.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ7_042613.pdf
Plan Management	**Q87:** What zONE	**A87:** The current training offered on	FAQ April 24,	CMS	https://www.regtap.info/uploads/library/

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Webinar: HIOS	trainings are appropriate for QHPs?	CMS zONE is listed under "Events" and includes "CMS zONE 101" (a webinar on basic features and how-to on CMS zONE.) Previous training (April 1st and April 3rd) included "Catch-up Direct Enrollment Technical Specification Review" and "Weekly Direct Enrollment Technical Review" sessions.	2013		PM_QHP_FAQ7_042613.pdf
Plan Management Webinar: HIOS	**Q1:** Can a unique Component Plan ID be used for both on and off exchange plans where the Product offers both, or should the Component Plan ID be different?	**A1:** A Component ID can be used both on and off the Exchanges provided that the benefits and cost sharing are the same.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q2:** Is a QHP a "Product" or is it a "Plan"?	**A2:** A QHP is a "plan".	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q3:** What is the difference between a QHP and a "Component" of a QHP? What are the definitions - Product, Plan, and Component?	**A3:** A Component ID is just the enumeration of a plan (QHP), which is a specific pairing of benefits to a given cost sharing option, which would allow a rate to be determined. A product is a set of benefits and cost-sharing options, like an issuer would submit to a state for approval.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q4:** What is the definition of a Product ID?	**A4:** A Product ID enumerates a specific set of benefits and cost-sharing options.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q5:** If an issuer offers HMO products in different parts of	**A5:** As long as the HMO product has the same benefits and cost-sharing options, it can be one Product ID.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	the state under different marketing names but with the same legal entity, can it still use one Product ID?				
Plan Management Webinar: HIOS	**Q6:** If an issuer wants to offer one standard Silver plan, and 3 Silver CSR plans, will the three plans each has its own Plan ID, and share the common Product ID?	**A6:** Enumeration of CSR plans is not done at on the issuer side. The issuer would use one Component (plan) ID for the Silver plan, and the identical (but cost-share reduced) plans would be differentiated by Variant IDs on the CMS side.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q7:** What entity is performing the review and confirmation of the requested role for a particular issuer ID?	**A7:** CCIIO will do these reviews.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q8:** Will each QHP cost-sharing variation need a component ID? Will a Silver plan in the Individual Exchange need 4 Plan IDs because there are 4 sets of specific cost sharing to the member?	**A8:** Each QHP cost-sharing variation (i.e. Indian within x of poverty level) does NOT need its own component ID. The Component ID enumerates plans. Any sort of CSR is done on the CMS side. But yes, Issuers would need different Component IDs if its cost-sharing options are different within a single product, so its $1500/30/30% plan would have a different ID than its 1000/25/25%.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q9:** If an issuer requests component	**A9:** If component IDs are not used, they do not need to be deleted. The issuer can	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	IDs in preparation for the QHP submission and then does not need the number requested, what is the process to delete those unused?	just leave them in the system, where they will not impact anything, but will be available when needed in the future.			
Plan Management Webinar: HIOS	**Q10:** Will Issuers use the existing HIOS product ID's for new Exchange products?	**A10:** If the Exchange plans would fit under an existing product, an existing product may be used for QHP submissions. This would include the benefits being the same. Exchange plans will use Standard Component IDs, and the variant IDs will be assigned on the CCIIO-side.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q11:** If an issuer edits a product, will that generate a new product ID?	**A11:** If an issuer edits a product, it will retain the same product ID.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q12:** Do issuers need new HIOS Plan IDs for the exchange or can an issuer use some of its current empty IDs?	**A12:** If an issuer has empty IDs, those should be available for use on the Exchange. If an issuer needs others, the issuer should request them via the Request Component IDs tab.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q13**: Do SCIDS need to be obtained in HIOS/RBIS by March 28th in order to be considered for QHP entry and submission for the FFE?	**A13:** No. They must be requested in time to make the QHP submission.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management	**Q14:** In which	**A14:** Plan IDs are not generated in the	FAQ April 25,	CMS	https://www.regtap.info/uploads/library/

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Webinar: HIOS	template is the Plan ID generated?	templates. Plan (Component) IDs are generated via the Request Component IDs tab in the HIOS Plan Finder module. Once an issuer has created Product IDs, the issuer can request Component IDs for each product.	2013		PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q15:** If an insurer already offers plans in a state, but wants to offer new plans/products through the Exchange, will a new ID need to be obtained?	**A15:** The issuer would not need to get a new Issuer ID, but may likely need to get new Product IDs if the Exchange products do not have identical benefits and cost-sharing options as the existing products.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q16:** Will there be a reconciliation process in order to ensure that the Plan ID and HIOS ID match in all systems?	**A16:** These validations are done both in the creation of these IDs and after templates are submitted.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q17:** Are all Plan IDs converting to the new 13-digit format with the hyphen, will they stay in the format that they are, or can we expect to be using both formats?	**A17:** They will stay in the current, 14-digit format.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q18:** If an issuer's EIN remains the same, but the name of the organization	**A18:** This can be done through the HIOS help desk.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	changes, what steps are needed to update this information?				
Plan Management Webinar: HIOS	**Q19:** Can a product contain more than 50 plan/component IDs via multiple requests?	**A19:** This is correct. The limit is 50 Component IDs per request, but issuers can request as many as needed for their submission.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q20:** How do we obtain the Associate Health Plan ID?	**A20:** This is done through the HPOES module in the HIOS system.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q21:** What is the processing time between submitting complete plan ID/component ID benefits and cost sharing via the Excel template in HIOS and viewing that information within the QHP application environment?	**A21:** Times will vary, but generally uploads complete in a few minutes.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q22:** If an issuer requests Product IDs today in HIOS for 2014 products on the Exchange templates, can the issuer use those Product IDs now but change the product names prior to the launch of the exchange?	**A22:** It is okay to change the product name after original submission in HIOS, but that will be time sensitive to the Exchange go-live.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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Plan Management Webinar: HIOS	**Q23:** Will vendor organizations receive an issuer ID?	**A23:** Vendors receive company IDs, but do not issue insurance, and therefore do not receive issuer IDs. If the vendor is contracting with an insurance issuer, it is assumed thee vendor will be working with the issuer using the issuer's issuer ID.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q24:** Will the Plan IDs for the Standard and Variation plans be transmitted on the 834?	**A24:** Yes, though variant ID may be entered in a separate field. Please refer to the 834 documentation.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q25:** Will HIOS still be used to generate Product ID's for State Partnership exchanges and QHP submissions via SERFF?	**A25:** Yes.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q26:** If someone has already registered your issuers, will that show up when attempting to register?	**A26:** Yes. When the Federal EIN is entered, the system will show all issuers associated to that EIN, so there will be no duplications.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q27:** Is there an accelerated route for obtaining HIOS Product ID's for new exchange metallic products?	**A27:** There is no accelerated process for obtaining HIOS product IDs for Exchange process, though those can be entered presently.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q28:** What if products are under contemporary review	**A28:** If the product is under review, please note under the "Approved" field that the product is not approved by the	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	by the state's department of insurance?	state. It will be possible to move forward with the process, but it will be noted and can be changed when the review is complete.			
Plan Management Webinar: HIOS	**Q29:** What is an issuer ID?	**A29:** An Issuer ID is a 5-digit ID that is unique to the provider/state pairing.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q30:** If a user sets up a person in role as backup, can they change that role to primary at a later date?	**A30:** An individual can change their role from Backup to Primary by accessing the Role Management tab in HIOS and making that request. You cannot do it for another person, but they can do it themselves.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q31:** Will issuers be allowed to have different user enter information into the HIOS system for the QHP certification process or will this just be the existing HIOS users?	**A31:** Each user can determine their user roles and use those roles to either submit or validate (or attest) data. Users can be specifically associated to the QHP module.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q32:** How does HIOS know a new user has the authority to set up an account and assign users?	**A32:** HIOS works to ascertain that a potential user is associated with the organization that they seek roles for. Additionally, once a user assigns a role to themselves, it will be associated with the organization and can be checked.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q33:** Are there restrictions or limitations to who gets access to the system?	**A33:** In order to enter the system, users must go through the EIDM system in the CMS Enterprise portal, and their requested HIOS roles must be approved on the CCIIO side.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q34:** Can primary and secondary work	**A34:** It is possible, but not recommended, because the system is not	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	in the web entry at the same time?	set up to dynamically update, creating the possibility of overwriting data and losing work.			
Plan Management Webinar: HIOS	**Q35:** Do the HIOS submitter and HIOS validator have to be two unique users?	**A35:** No, they do not.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q36:** For the EIDM setup, does an adverse credit score disqualify an employee from signup?	**A36:** No. Credit score had no impact. At this time, the credit verification has been suspended.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q37:** For EIDM, How often is the identify check re-validated?	**A37:** The check is only done once.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q38:** How does a company change the person who is already set up as the issuer - is there a way to delete and change?	**A38:** Please contact the HIOS help desk in order to delete users.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q39:** Which user roles can add/edit product information?	**A39:** Submitters for any module can add/edit product information, while validators can do some editing, depending on the module.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q40:** Is there a deadline for HIOS/Plan Finder registration for a 1/1/14 coverage effective date?	**A40:** The deadline is essentially the latest date that will still allow an issuer to complete its QHP submission.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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Plan Management Webinar: HIOS	**Q41:** When an access holder leaves a company, is there a way to remove future access to the HIOS Rx tools on behalf of that company?	**A41:** The user or the company can contact the HIOS help desk and have those roles removed.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q42:** On HIOS, the role job-aid mentioned a contractor role. How do issuers assign that role?	**A42:** There are CMS contractor roles not revealed to issuers. Contractors working on behalf of issuers will be assigned issuer roles.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q43:** How many HIOS users (validators and submitters) can be used per Health Plan or Issuer?	**A43:** There is no restriction on this number.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q44:** Is there a limit to how many USP user roles an organization may have?	**A44:** There is not a limit to the number of USP users per issuer.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q45:** If an issuer has identified QHP Submitter and Validator Users that are associated with multiple Issuers, can the issuer set up QHP User Access for multiple Issuers instead of doing one	**A45:** This must be done one issuer at a time.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf

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	Issuer at a time?				
Plan Management Webinar: HIOS	**Q46:** Do Issuers only have to submit RBIS information and not plan finder if the issuer does not expect to participate on the exchange?	**A46:** Any product that is offered in any state must be entered into the HIOS Plan Finder module, whether on the Exchange or off. If a plan is not offered on the exchange, it must be submitted to RBIS.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q47:** Is the HIOS product entry only for intended exchange products, or for all products issuers currently offer or want to offer in the future?	**A47:** Any product that is offered in any state must be entered into the HIOS Plan Finder module, whether on the Exchange or off. If a plan is not offered on the exchange, it must be submitted to RBIS.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q48:** Does the HIOS information need to be submitted prior to a certain date?	**A48:** HIOS information must be submitted before issuers can begin the QHP application, but there is not a limit outside of the QHP deadline.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q49:** If an issuer currently files its off exchange rates through SERFF can the issuer continue to do so, or does the issuer have to do it through RBIS?	**A49:** Issuers are required to submit all off-Exchange plans to RBIS, in addition to any SERFF requirement.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q50:** Will the NAIC/SERFF templates be replacing the current RBIS templates?	**A50:** That is not the plan for the near future. There will be an announcement well before any change to the RBIS template is made.	FAQ April 25, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ8_042313.pdf
Plan Management	**Q51:** Will QHP	**A51:** The current design is to keep the	FAQ April 25,	CMS	https://www.regtap.info/uploads/library/

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Webinar: HIOS	submissions ultimately be posted to Healthcare.gov's plan finder tool?	plans separate for the time being. Comments and suggestions are welcome.	2013		PM_QHP_FAQ8_042313.pdf
Plan Management Webinar: HIOS	**Q84:** How do issuers use HIOS if they are in a non-Partnership FFE?	**A84:** To offer QHPs in non-Partnership FFEs for the 2014 plan year, health insurance issuers will complete QHP Applications electronically through HIOS. Before submitting an application, issuers must gain access to HIOS and define user roles (such as data submitter, data validator, and attester), and obtain HIOS user IDs. HHS expects that between April 1 and April 30, 2013, the issuers will access the QHP Application in HIOS to submit all information necessary for certification of health plans as QHPs. The QHP Application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 CFR parts 155 and 156 and other programmatic requirements necessary for the operational success of an Exchange, and provide requested supporting documentation. These attestations will also apply to vendors and contractors of the issuer or company.	FAQ May3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf
Plan Management Webinar: HIOS	**Q85:** How do issuers use HIOS if they are	**A85:** There are several instances when a user submitting a QHP Application to a	FAQ May3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	in a Partnership state?	SERFF State will need to utilize HIOS. First, anyone using the HHS/SERFF templates will need to access HIOS to obtain product and plan IDs. If your organization has been selling in the Individual or Small Group Markets, than you should have been entering HIOS for the PlanFinder collection associated with HealthCare.gov, and the process is exactly the same. Issuers need to submit basic information on their form filings as "products" which generates product IDs. All QHP submissions must link up to a reported product in HIOS. Once you have submitted that basic information, you can request a block of Standard Component IDs (formerly called plan IDs). Instructional materials are available at the REGTAP site https://www.REGTAP.info/. If you have staff who have been reporting for HealthCare.gov, those individuals should be able to walk you through the process. In addition to the above, in Partnership States, HIOS will receive data from SERFF for use in finalizing the QHP Certification process. Issuers who submitted QHP Applications in SERFF will need to interact with HIOS as part of the Plan Preview period (currently estimated August 22-26) as well as to finalize the certification of QHPs at the end of the process and sign agreements with HHS (currently			

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		estimated September 5-9). Also, existing filing and submission requirements for other HHS programs still apply, such as the requirements related to providing rate increase submissions under CFR 45 154.215. If you plan to offer products outside of the Federally Facilitated Exchange, please follow the rate review filing requirements under CFR 45 154.220 and contact your State to determine state specific filing requirements. As noted in the Health Insurance Market Rules; Rate Review final rule http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf when making a rate filing submission, all on- and off-Exchange products must file the Part I Unified Rate Review template and Part III Actuarial Memorandum into HIOS. If an issuer is not applying to offer any QHPs in the same risk pool, the Part I Unified Rate Review template and Part III Actuarial Memorandum are due on the timeline set by the state, but before January 1, 2014.			
Plan Management Webinar: Premium Stabilization Programs	**Q45:** If the issuer has a capitated plan, does the issuer need to submit the claims from the PCP? These claims will have a $0 Allowed Cost amount because the provider receives a	**A45:** The Edge Server will accept claims that have a $0 allowed amount. For capitated services, Issuers will need to derive (or estimate) a paid amount for these services in order for them to be considered for reinsurance. In addition, the inbound claim file layout contains a field to indicate a derived amount has been computed for capitated	FAQ May3, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ9v2_050313.pdf

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	set payment; will these claims pass the Edge Server Edit?	arrangements. Further information and specific file layouts pertaining to capitated arrangements will be covered in the May 8th Distributed Data Collection (Edge Server) webinar. You can register for this webinar at https://www.REGTAP.info/.			
Plan Management Webinar: General	**Q58:** How do issuers remove HIOS-EIDM accounts for terminated employees?	**A58:** Please call the Help Desk and have the terminated or departed employee removed from the organization.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: General	**Q59:** We just submitted our state filing and the rates template was too large to upload into SERFF. SERFF has a maximum file size of 3 MB. The XML version is difficult for the state to read, so unless they know how to translate it, they will be confused.	**A59:** After the .xml file is uploaded, the system validates the file, then returns an Excel version of the data. This is available to submitters and reviewers. Additionally, SERFF has increased its maximum file size.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: General	**Q60:** Will there be a Confidentiality template to identify fields on the templates that are proprietary or confidential?	**A60:** Currently, the data supplied in the templates will be used only for QHP certification purposes and for population of the FFM website, for example, for population of the premium calculator. To the extent that data is being entered for rate review purposes, the process related to proprietary information that is	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		currently in place under that program would apply to that information. We may receive Freedom of Information Act requests or other data release requests for this information, and we will work on a process for handling these requests while protecting issuer confidentiality.			
Plan Management Webinar: General	**Q61:** When user clicks on the Validator tab, the screen goes white and nothing happens. When refreshing or going back an error is encountered. The application will eventually let the user go back. These errors prevent the user from completing the test script.	**A61:** This occurs for users that have both the Submitter and Validator roles. You may navigate successfully through the sections of the module from the Summary Page rather than using the links at the side of the page.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Plan Management Webinar: General	**Q62:** If we are not filing to be a part of the Exchange/offer QHPs, do we need to do anything?	**A62:** An issuer is not required to notify CMS that it will not seek QHP certification. However, existing filing and submission requirements for other CMS programs still apply, such as the requirements related to providing rate increase submissions under 45 CFR 154.215. If you plan to offer products outside of the Federally Facilitated Marketplace, please follow the rate review filing requirements under 45 CFR 154.220 and contact your State to	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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		determine state specific filing requirements. As noted in the final Market Rules at: http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf, when making a rate filing submission, all on- and off-Exchange products must file the Part I Unified Rate Review template and Part III Actuarial Memorandum into HIOS. If an issuer is not applying to offer any QHPs in the same risk pool, the Part I Unified Rate Review template and Part III Actuarial Memorandum are due on the timeline set by the state, but before January 1, 2014.			
Plan Management Webinar: General	**Q63:** I am trying to clarify data submission requirements for April 30 as applicable to FFE states. In the QHP Certification PRA notice, Appendix D has data elements related to the EDGE server listed as required for the QHP application process. None of the QHP application templates available via HIOS have a place to enter the Edge server related data. Please	**A63:** Appendix D represents data required for reinsurance, risk adjustment, and payment operations. Those data elements will be collected outside of the QHP application process as they are not required for QHP certification. The collection of the Appendix D data will occur later this year. The PRA package can be found at: http://www.reginfo.gov/public/do/PRAViewICR?ref_nbr=201303-0938-004.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf

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	confirm that we are not required to submit the Edge Serve data elements described in Appendix D of the QHP Certification PRA notice with the April 30th QHP application submission.				
Plan Management Webinar: General	**Q64:** The file is not automatically defaulting to be saved in .xml format as specified in test scenarios. It defaults to .xls instead.	**A64:** Excel 2007 automatically defaults to the current file name and format. You will need to manually select the .xml format when you save the finalized submission file generated by the finalize template macro.	FAQ April 18, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP041113_FAQs5_041813.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q1:** Does HHS want the HIOS plan ID used in the PlanID field in the Edge Server Enrollment Submission (ESES) for the Edge Server?	**A1:** The enrollment submission for the Edge Server uses the HIOs ID to identify the issuer and the corresponding HIOS standard component ID for the plan. This information will be provided in the Edge Server ICD (interface control document).	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q2:** Issuers have heard that they would be receiving and sending 834 files for enrollment transactions. Are issuers now using both the 834 and XML files?	**A2:** The Edge Server accepts XML files only and is strictly for the purpose of Risk Adjustment and Reinsurance data collection. The 834 transaction referenced is unique to Exchange enrollments.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q3:** Could HHS provide more guidance on the masked enrollee ID numbers? For instance, if issuers assign a unique ID number today that is not the member's SSN, are issuers required to map their current ID number to another unique ID number solely for the Edge Server?	**A3:** In the HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, regulation text §153.720 states that an issuer may not include personally identifiable information in the masked enrollee identification number or use the same masked enrollee identification number for different enrollees enrolled with the issuer. If the current enrollee ID number does not violate one of these requirements, then the current ID may be used as the masked enrollee identification number.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q4:** Reinsurance only impacts the Individual market. Risk Adjustment impacts both the Individual and Small Group markets. Based on this, does HHS anticipate different record layouts or 'uploads' for Reinsurance vs. Risk Adjustment?	**A4:** In Distributed Data Collection there are submissions based on enrollment, medical claims, and pharmacy claims. The record layouts for each of these transaction types includes the data elements to address both reinsurance and risk adjustment as appropriate. Additional details will be provided during the May 8th and May 22nd webinars.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q5:** What is the data frequency of data submission? Is it quarterly or can issuers submit monthly or twice	**A5:** As stated in the preamble of the HHS Notice of Benefit and Payment Parameters for 2014, Final Rule (Section III.G.2.h), HHS recommends issuers submit data at least quarterly throughout the benefit year. Issuers have	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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	monthly?	the flexibility to submit more frequently (e.g. bi-weekly, monthly). HHS recommends monthly file submissions or more frequent submissions based on Issuer file size and processing time.			
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q6:** How should issuers treat claims from capitated arrangements on the Edge Server Medical Claim Submission?	**A6:** The Edge Server will accept claims that have a $0 allowed amount. For capitated services, Issuers will need to derive (or estimate) a paid amount for these services. In addition, the inbound claim file layout contains a field to indicate a derived amount has been computed for capitated arrangements (§ 153.710(c)). Further information and specific file layouts pertaining to capitated arrangements will be covered in the May 22nd Distributed Data Collection (Edge Server) webinar.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	**Q7:** Has a decision been made as to whether or not additional diagnosis code information can be submitted from chart reviews (similar to the RAPS file process for Medicare Advantage)? If it is allowed, would issuers use the Medical Claim format to submit?	**A7:** Guidance on the use of chart reviews as a source of diagnosis codes for risk adjustment will be provided by HHS prior to January 1, 2014.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data	**Q8:** Will the	**A8:** No. All claims and enrollment files	FAQ May 9,	CMS	https://www.regtap.info/uploads/library/

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Collection for Reinsurance and Risk Adjustment Webinar: Data Submission	submission process be similar to the Medicare Part D data reporting?	will reside on the issuer's edge server. There is no centralized data collection by HHS/CMS as is the case with Medicare Part D.	2013		DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q9:** If an organization has two licensed entities (with two separate HIOS ID's), can the organization submit all of its data to one Edge Server?	**A9:** A single Edge Server may be used to submit data for multiple plans or multiple issuers. Issuers can submit all of their data to one Edge Server as long as they are under one insurance company that is one legal entity.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q10:** Will the HHS Software create the data repositories or are there database components that must be built on the Edge Server (s)?	**A10:** The software that HHS pushes to the Edge Server will create the data repositories necessary for processing. Issuers will load the submissions to the Edge Server and the Edge Server will provide response reports.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q11:** Who are some third party vendors providing an Edge server environment?	**A11:** HHS does not make recommendations regarding third party vendors.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q12:** Why was a new methodolgy chosen instead of leveraging Medicare's encounter reporting process?	**A12:** Concerns were expressed by stakeholders about HHS having access to proprietary data and storing in a centralized repository. To respond to the concerns, HHS adopted a distributed data approach that elimnates the need for centralized data collection and helps ensure privacy through the application of masked enrollee identifiers.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data	**Q13:** How long does	**A13:** Although we have not finalized	FAQ May 9,	CMS	https://www.regtap.info/uploads/library/

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Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	the data for reinsurance and risk adjustment need to be retained for on the Edge Server?	our policy, we anticipate that an issuer Edge Server will need to store 3 years' worth of enrollment and claims data. However, it is important to note that in accordance with Section 153.620 of the Federal Regulations, Issuers are required to retain any information requested to support risk adjustment data validation for a period of at least 10 years after the date the data are reported.	2013		DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q14:** When will XML extract guides be made available?	**A14:** The Interface Control Document will be included in future Distributed Data Collection webinar sessions (May 8th and May 22nd). This document contains the information necessary for building XMLs for the Edge Server Submission files.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q15:** Are Distributed Data Collection webinar presentation slides available to issuers?	**A15:** Yes, the presentation slides from the webinar are available on REGTAP in the library. They are listed in the library as Distributed Data Collection for Reinsurance and Risk Adjustment Overview (03/20/13).	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q16:** What is the rationale for not releasing the ICD now?	**A16:** HHS is incrementally releasing the ICD to provide an opportunity for questions related to each file layout. The entire ICD will be available after the completion of the May 22nd webinar.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q17:** Is there an Edge Server template along with the SERFF templates and where does it reside?	**A17:** No, the Edge Server interface control document is not part of the SERFF templates.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q18:** Will there be a Companion Guide claims data like the Companion Guide for Enrollment and if so, when will it be available?	**A18:** No, the Enrollment Companion Guide, currently available, is for enrollment submissions to the Federally-Facilitated Marketplace. This is a different enrollment transaction than that for the Edge Server. For the Edge Server, HHS will release an Interface Control Document (ICD) that details the rules and formats for Edge Server submissions, including enrollment, medical claims, and pharmacy claims.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q19:** When will the open source code be available for download for use outside of deployment to an Edge Server?	**A19:** Software allowing Issuers to replicate the Edge Server process will be provided on or before January 1, 2014. The software code for Risk Adjustment and Reinsurance payment calculations will be available in 2014.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q20:** For the Edge Server are there any file specification for the data collection currently avilable?	**A20:** As documentation becomes available, such as the Interface Control Document (ICD) and Welcome Packet, they wll be placed in the REGTAP library. In addition, the file layouts (specifications) for enrollment will be addressed in the webinar on May 8 and for Pharmacy and Medical claims on May 22.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q21:** We have heard that the edge server information is not required for submission with the QHP application for April 30, 2013. We	**A21:** Your understanding is correct. Edge Server information is not required with the QHP application by April 30, 2013. Edge Server information is not needed until an issuer has an Edge Server.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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	heard that this information, the information from Appendix D, would not be required until the issuer actually had the edge server in place. Could you please confirm if this is factual or if this information is needed by April 30?				
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q22:** Will there be any delays in the timeline considering no data specifications have been released but testing is expected to begin in March 2013?	**A22:** While the timeline is tentative, provisioning and testing are currently scheduled to begin in September 2013, not March 2013.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q23:** Can HHS please provide more details regarding partner testing? What are the objectives? Can HHS provide volume requirements? What level of data quality is expected?	**A23:** As part of the provisioning process in the fall of 2013, HHS will provide more details about testing your edge server. Information about Edge Server hardware specifications will be provided during the April 24th webinar.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar:	**Q24:** To what email address should issuers send questions during	**A24:** Questions may be sent to registrar@REGTAP.info. Technical questions may be sent toCMS_FEPS@cms.hhs.gov.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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Edge Server Operations	analysis?				
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q25:** How will HHS connect to the Edge Server to pull the data SFTP, web services, VPN, etc.?	**A25:** All communication between the Edge Server and the CMS Management Console (CMSMC) will use Secure Sockets Layer (SSL), namely SSH/SFTP and HTTPS.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q26:** Will participants from the beta test have their Edge Server reprovisioned in total or will they just be 'pushed' an update?	**A26:** Beta testers will not have to be reprovisioned if they continue using the same Edge Server. These issuers will simply have their tables truncated. Beta testers who upgrade their Edge Server will need to be reprovisioned.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Operations	**Q27:** Are there specific anti-virus and anti-intrusion softtware requirements?	**A27:**Issuers should follow their corporate data security standards	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Specifications	**Q28:** Can HHS please provide issuers with Edge Server hardware specifications?	**A28:** Details about Edge Server hardware specifications will be made available on the April 24th webinar.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Specifications	**Q29:**Does HHS have guidelines based on membership or claims volume on the size of the server, and required memory, space, etc?	**A29:** Details about Edge Server hardware specifications will be made available on the April 24th webinar.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk	**Q30:** Can the Edge Server run in a virtual environment?	**A30:** The Edge Server must be a physical server. At this time the Edge Server does not support Blade, virtual	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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Adjustment Webinar: Edge Server Specifications		machines, or SAN.			
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Specifications	**Q31:** Do issuers need seperate Edge Server for each plan?	**A31:** No, issuers do not need a separate Edge Sever for each plan. A single Edge Server may be used to submit data for multiple plans or multiple issuers. Issuers can submit all of their data to one Edge Server as long as they are under one insurance company that is one legal entity.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Specifications	**Q32:** Will vendors servicing multiple issuers be able to submit the Risk Adjustment and Reinsurance data through one Edge server as indicated in the 'Third Party Administrator' scenario?	**A32:** A single Edge Server may be used to submit data for multiple plans or multiple issuers. Issuers can submit all of their data to one Edge Server as long as they are under one insurance company that is one legal entity.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar: Edge Server Specifications	**Q33:** If states are implementing risk adjustment in the future using the distributed approach, shall the states use a different physical server?	**A33:** A state that chooses to operate reinsurance and/or risk adjustment will decide how to collect the necessary data.	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf
Distributed Data Collection for Reinsurance and Risk Adjustment Webinar:	**Q34:** It was mentioned several times in the March 20 presentation that	**A34:** The summary and detailed reports from the Edge Server are provided to issuers after each Edge Server submission. These files will contain	FAQ May 9, 2013	CMS	https://www.regtap.info/uploads/library/DDC_for_RI_RA_FAQ1_050913.pdf

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Reports	detailed and summary reports will be available to issuers quarterly. Will these reports include only the issuer's data or will they also include market information?	information about the submitted file only. Reporting related to the Risk Adjustment and Reinsurance Programs specifically is currently under development.			
Affordable Care Act Implementation: Compliance	**Q1:** Under the Affordable Care Act, there are various provisions that apply to group health plans and health insurance issuers and various protections and benefits for consumers that are beginning to take effect or that will become effective very soon. What is the Departments' basic approach to implementation?	**A1:** The Departments are working together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and are working with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly, minimizing any disruption to existing plans and practices.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act Implementation:	**Q2:** After the interim final regulations on	**A2:** For purposes of determining whether an insured group health plan is	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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Grandfathered Health Plans	grandfathered health plans were issued, some issuers commented that they do not always have the information needed to know whether (or when) an employer plan sponsor changes its rate of contribution towards the cost of group health plan coverage. (Generally, the interim final regulations provide that a group health plan or health insurance coverage will cease to be a grandfathered health plan if the employer decreases its contribution rate based on cost of coverage towards the cost of coverage by more than 5 percentage points below the contribution rate on March 23, 2010.)	a grandfathered health plan, what steps should issuers and employer plan sponsors take to communicate regarding changes to the plan sponsor's contribution rate? The Departments have determined that, until the issuance of final regulations, they will not treat an insured group health plan that is a grandfathered plan as having ceased to be a grandfathered health plan immediately based on a change in the employer contribution rate if the employer plan sponsor and issuer take the following steps: • Upon renewal, an issuer requires a plan sponsor to make a representation regarding its contribution rate for the plan year covered by the renewal, as well as its contribution rate on March 23, 2010 (if the issuer does not already have it); and • The issuer's policies, certificates, or contracts of insurance disclose in a prominent and effective manner that plan sponsors are required to notify the issuer if the contribution rate changes at any point during the plan year. For policies renewed prior to January 1, 2011, issuers should take these steps no later than January 1, 2011. If these steps are taken, an insured group health plan			

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		that is a grandfathered health plan will continue to be considered a grandfathered health plan. The relief in this Q&A2 will no longer apply as of the earlier of the first date on which the issuer knows that there has been at least a 5-percentage-point reduction or the first date on which the plan no longer qualifies for grandfathered status without regard to the 5-percentage-point reduction. Moreover, nothing in the Affordable Care Act or the interim final regulations prevents a policy, certificate, or contract of insurance from requiring a plan sponsor to notify an issuer in advance (e.g., 30 or 60 days in advance) of a change in the contribution rate.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q3:** Similarly, multiemployer plans do not always know whether (or when) a contributing employer changes its contribution rate as a percentage of the cost of coverage. What steps should multiemployer plans take to communicate with contributing employers regarding employer	**A3:** If multiemployer plans and contributing employers follow steps similar to those outlined in Q&A2, above, the same relief will apply to the multiemployer plan unless or until the multiemployer plan knows that the contribution rate has changed.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	contributions towards coverage?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q4:** Also with respect to multiemployer plan coverage, some multiemployer plans have stated that it is common for such plans to have either a fixed-dollar employee contribution or no employee contribution towards the cost of coverage. In such cases, is it relevant if a contributing employer's contribution rate changes (for example, after making up a funding deficit in the prior year or to reflect a surplus), provided any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered and there continues to be no employee	**A4:** In this circumstance, if there is no increase in the employee contribution towards coverage and any changes in the coverage terms would not otherwise cause the plan to cease to be grandfathered, a change in a contributing employer's contribution rate will not, in and of itself, cause a plan that is otherwise a grandfathered health plan to cease to be a grandfathered health plan.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	contribution or no increase in the fixed-dollar employee contribution towards the cost of coverage?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q5:** Are the Departments receiving other comments and questions regarding the grandfather regulations? Is more guidance expected?	**A5:** The Departments invited comments on their interim final grandfather regulations, as well as on the appeals regulations and other provisions whose applicability is affected by status as a grandfathered health plan. The Departments have issued some sub-regulatory guidance on the appeals regulations and will continue to review and evaluate comments on these and other regulations, and might issue further sub-regulatory guidance on selected issues as comments are evaluated. Final regulations on the various interim final regulations recently issued under the Affordable Care Act are expected to be published beginning next year.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act Implementation: Grandfathered Health Plans	**Q6:** Will the Departments change the current rules so that a grandfathered group health plan that changes carriers does not relinquish its status as a grandfathered health plan?	**A6:** The Departments anticipate that they will shortly address the circumstances under which grandfathered group health plans may change carriers without relinquishing their status as grandfathered health plans.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act	**Q1:** Our company	**A1:** No. Paragraph (g)(1) of the	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Grandfathered Health Plans	sponsors a group health plan for our employees that has been in effect since March 23, 2010. We and the issuer of the policy under the plan are considering whether we could make various changes to the plan without losing grandfathered status. If we avoid making any of the six specific changes described in paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, are there other changes to our existing plan/policy that we need to be concerned could cause it to relinquish grandfathered status?(1)	Departments' interim final grandfather regulations provides that any of six changes (measured from March 23, 2010) are considered to change a health plan so significantly that they will cause a group health plan or health insurance coverage to relinquish grandfather status. Briefly stated, these six changes are: 1.Elimination of all or substantially all benefits to diagnose or treat a particular condition. 2.Increase in a percentage cost-sharing requirement (e.g., raising an individual's coinsurance requirement from 20% to 25%). 3.Increase in a deductible or out-of-pocket maximum by an amount that exceeds medical inflation plus 15 percentage points. 4.Increase in a copayment by an amount that exceeds medical inflation plus 15 percentage points (or, if greater, $5 plus medical inflation). 5.Decrease in an employer's contribution rate towards the cost of coverage by more than 5 percentage points. 6.Imposition of annual limits on the dollar value of all benefits below specified amounts For a plan that is continuing the same policy, these six changes are the only			aca2.html

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		changes that would cause a cessation of grandfather status under the interim final regulations. (As noted, the Departments are separately considering under what circumstances otherwise grandfathered plans may change issuers without relinquishing their status as grandfathered health plans.)			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q2:** My plan offers three benefit package options – a PPO, a POS arrangement, and an HMO. If the HMO relinquishes grandfather status, does that mean that the PPO and POS arrangement must also relinquish grandfather status?	**A2:** No. The grandfather analysis applies on a benefit-package-by-benefit-package basis. In this situation, it is permissible to treat the PPO, POS arrangement, and HMO as separate benefit packages. Accordingly, if any benefit package ceases grandfather status, it does not affect the grandfather status of the other benefit packages.	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html
Affordable Care Act Implementation: Grandfathered Health Plans	**Q3:** How do the Departments' interim final grandfather rules regarding changes in employer contributions apply where an employer restructures its tiers of coverage?	**A3:** The interim final grandfather regulations provide that the standards of paragraph (g)(1)(v) for employer contributions (listed above as item (5) in Q&A-1) apply on a tier-by-tier basis. As a result, if a group health plan modifies the tiers of coverage it had on March 23, 2010 (for example, from self-only and family to a multi-tiered structure of self-only, self-plus-one, self-plus-two, and self-plus-three-or-more), the employer contribution for any new tier would be tested by comparison to the contribution rate for the corresponding tier on March	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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		23, 2010. In this example, if the employer contribution rate for family coverage was 50 percent on March 23, 2010, the employer contribution rate for any new tier of coverage other than self-only (i.e., self-plus-one, self-plus-two, self-plus-three or more) must be within 5 percentage points of 50% (i.e., at least 45 percent). If, however, the plan adds one or more new coverage tiers without eliminating or modifying any previous tiers and those new coverage tiers cover classes of individuals that were not covered previously under the plan, the new tiers would not be analyzed under the standards of paragraph (g)(1). Therefore, for example, if a plan with only a self-only coverage tier added a family coverage tier, the level of employer contribution toward the family coverage would not cause the plan to lose grandfather status.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q4:** If an employer plan sponsor raises the copayment level for a category of services (such as outpatient or primary care) by an amount that exceeds the standards set forth in paragraph (g)(1) of the interim final	**A4:** Yes. Each change in cost sharing is separately tested against the paragraph (g)(1) standards of the Departments' interim final grandfather regulations.	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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	regulations, but retains the copayment level for other categories of services (such as inpatient care or specialty care), will that cause the plan to relinquish grandfather status?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q5:** How do the Departments' interim final grandfather regulations affect wellness programs sponsored by group health plans?	**A5:** Group health plans may continue to provide incentives for wellness by providing premium discounts or additional benefits to reward healthy behaviors by participants or beneficiaries, by rewarding high quality providers, and by incorporating evidence-based treatments into benefit plans.(2) However, penalties (such as cost-sharing surcharges) may implicate the paragraph (g)(1) standards listed above in Q&A-1 and should be examined carefully. In addition, plans should take steps to ensure compliance with applicable nondiscrimination rules (such as the HIPAA(3) nondiscrimination rules for group health plans and group health insurance coverage with respect to an individual based on a health status related factor) and any other applicable Federal or State law.	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html
Affordable Care Act Implementation:	**Q1:** The Departments' interim	**A1:** A grandfathered health plan will comply with this disclosure requirement	FAQ Part IV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca4.html

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Grandfathered Health Plans	final grandfather regulations provide that, to maintain status as a grandfathered health plan, a group health plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan. Must a grandfathered health plan provide the disclosure statement every time it sends out a communication, such as an EOB (explanation of benefits), to a participant or beneficiary? If not,	if it includes the model disclosure language provided in the Departments' interim final grandfather regulations (or a similar statement) whenever a summary of the benefits under the plan is provided to participants and beneficiaries. For example, many plans distribute summary plan descriptions upon initial eligibility to receive benefits under the plan or coverage, during an open enrollment period, or upon other opportunities to enroll in, renew, or change coverage. While it is not necessary to include the disclosure statement with each plan or issuer communication to participants and beneficiaries (such as an EOB), the Departments encourage plan sponsors and issuers to identify other communications in which disclosure of grandfather status would be appropriate and consistent with the goal of providing participants and beneficiaries information necessary to understand and make informed choices regarding health coverage.			

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	how does a grandfathered health plan comply with this disclosure requirement?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q2:** If an individual health insurance policy that was in place on March 23, 2010 included a feature that allowed a policy holder to elect an option under which he or she would pay a reduced premium in exchange for higher cost sharing, could such an election be made after March 23 without affecting the policy's grandfather status even if the increase in cost sharing for the individual would exceed the limits under the grandfather rule on increases in cost sharing?	**A2:** Yes. The cost-sharing level that would apply under this option would be grandfathered as part of the policy in place on March 23, 2010 even if it did not apply for the particular individual at that time. As long as the policy holder had that option available on March 23 under the policy, he or she could exercise the option after March 23 without affecting grandfather status, even if the result would be that the particular individual's cost-sharing would increase as a result of electing this option by an amount in excess of the grandfather rule limits.	FAQ Part IV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca4.html
Affordable Care Act Implementation: Grandfathered Health Plans	**Q3:** An employer has maintained a plan since before enactment of the	**A3:** Yes. In accordance with the preamble to the Departments' interim final regulations implementing PHS Act section 2711, for plan years beginning	FAQ Part IV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca4.html

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	Affordable Care Act that reimburses expenses for special treatment and therapy of eligible employees' children with physical, mental, or developmental disabilities. The treatment or therapy is not covered by the employer's primary medical plan or plans. Reimbursable expenses may include expenses for special treatment or therapy from licensed clinics or practitioners, day or residential special care facilities, special education facilities for learning-disabled children, or camps offering medically oriented programs that are part of a child's continued treatment, or for special devices. The plan is operated separately from the employer's primary	before the issuance of final regulations defining "essential health benefits," for purposes of enforcement, the Departments will take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits." (Of course, the regulations may differ in their definition of "essential health benefits" from reasonable interpretations used before the regulations are issued.) Accordingly, in the case of plans described above, for such plan years: (i) the Departments will treat as a reasonable good faith interpretation of section 2711 of the PHS Act and the regulations thereunder the position that the imposition of the per-child lifetime dollar limit on benefits provided under such plans does not violate the lifetime limit prohibition, and (ii) the imposition by such plans of such a limit will not result in an enforcement action by the Departments against such plans under PHS Act section 2711.			

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	medical plans; employees who are otherwise eligible may participate in the plan without participating in those primary medical plans. The plan limits the total benefits for any eligible child to a specified lifetime dollar limit. Would it be a reasonable good faith interpretation of the Affordable Care Act and the regulations thereunder for the plan sponsor to take the position that the plan does not violate the prohibition, under section 2711 of the Public Health Service Act (PHS Act) and the related interim final regulations, on imposing a lifetime dollar limit on "essential health benefits," as defined in section 1302(b) of the Affordable Care Act (the lifetime				

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	limit prohibition)?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q7:** My plan terms include out-of-pocket spending limits that are based on a formula (a fixed percentage of an employee's prior year compensation). If the formula stays the same, but a change in earnings results in a change to the out-of-pocket limits such that the change exceeds the thresholds allowed under paragraph (g)(1) of the interim final regulations relating to grandfathered health plans, will my plan relinquish grandfather status?	**A7:** No. The Departments have determined that if a plan or coverage has a fixed-amount cost-sharing requirement other than a copayment (for example, a deductible or out-of-pocket limit) that is based on a percentage-of-compensation formula, that cost-sharing arrangement will not cause the plan or coverage to cease to be a grandfathered health plan as long as the formula remains the same as that which was in effect on March 23, 2010. Accordingly, if the percentage-of-compensation formula for determining an out-of-pocket limit is unchanged and an employee's compensation increases, then the employee could face a higher out-of-pocket limit, but that change would not cause the plan to relinquish grandfather status.	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html
Affordable Care Act Implementation: Grandfathered Health Plans	**Q1:** What is the scope of the anti-abuse rule in paragraph (b)(2) of the interim final regulations relating to grandfather status? In particular, what is a "bona fide	**A1:** The interim final regulations relating to status as a grandfathered health plan generally state that transferring employees from one grandfathered plan or benefit package (transferor plan) to another (transferee plan) will cause the transferee plan to relinquish grandfather status if amending the transferor plan to replicate	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html

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	employment-based reason" for employees enrolled in a benefit package that is being eliminated to be transferred into another benefit package?	the terms of the transferee plan would have caused the transferor plan to relinquish grandfather status. However, the interim final regulations also provide that this rule applies only if there was no bona fide employment-based reason to transfer the employees. For purposes of paragraph (b)(2) of the interim final regulations relating to status as a grandfathered health plan, the Departments interpret the term "bona fide employment-based reason" to embrace a variety of circumstances. These circumstances (under which a transfer would not cause cessation of grandfather status) include, but are not limited to, any of the following: 1.When a benefit package is being eliminated because the issuer is exiting the market; 2.When a benefit package is being eliminated because the issuer no longer offers the product to the employer (for example, because the employer no longer satisfies the issuer's minimum participation requirement); 3.When low or declining participation by plan participants in the benefit package makes it impractical for the plan sponsor to continue to offer the benefit package; 4.When a benefit package is eliminated			

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		from a multiemployer plan as agreed upon as part of the collective bargaining process; or 5.When a benefit package is eliminated for any reason and multiple benefit packages covering a significant portion of other employees remain available to the employees being transferred. The foregoing is not intended to be an exhaustive list of circumstances that will be deemed to satisfy the bona fide employment-based reason condition. There may be many other circumstances in which a benefit package is considered to be eliminated for a bona fide employment-based reason.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q2:** My plan bases the level of cost sharing for brand-name prescription drugs on the classification of the drugs under the plan as having or not having generic alternatives. The classification of a drug that had no generic alternative changes because a generic alternative becomes available and is added to the formulary, with a	**A2:** No. For example, if, on March 23, 2010, the terms of the plan included prescription drug benefits with different cost sharing divided into tiers as follows: • Tier 1 includes generic drugs only; • Tier 2 includes brand name drugs with no generic available; • Tier 3 includes brand name drugs with a generic available in Tier 1; and • Tier 4 includes IV chemotherapy drugs. A drug was previously classified in Tier 2 as a brand name drug with no generic available. However, a generic alternative for the drug has just been released and is added to the formulary.	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html

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	resulting increase in the cost-sharing level for the brand-name drug. Does that increase cause my plan to relinquish its grandfather status?	Since the generic is now available, the plan moves the brand name drug into Tier 3 and adds the generic to Tier 1. This movement of the brand name drug into a higher cost-sharing tier does not cause the plan to relinquish grandfather status.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q3:** A previous FAQ addressed the interaction of value-based insurance design (VBID) and the no cost-sharing preventive care services requirements. See http://www.dol.gov/ebsa/faqs/faq-aca5.html . In that example, a group health plan did not impose a copayment for colorectal cancer preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting generally required a $250 copayment, although	**A3:** No. This increase in the copayment for these preventive services solely in the in-network outpatient hospital setting (subject to the waiver arrangement described above) without any change in the copayment in the in-network ambulatory surgery center setting would not be considered to exceed the thresholds described in paragraph (g)(1) of the interim final regulations on grandfather status and thus would not cause the plan to relinquish grandfather status. The Departments are seeking further information on VBID and wellness programs and are planning to address issues relating to those designs and programs in future regulations. Comments from plan sponsors have expressed an interest in being able to retain grandfather status notwithstanding certain changes in plan terms that are intended to implement VBID and wellness programs. As the regulatory process progresses, the Departments will be giving close attention to these comments, and further	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html

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	the copayment was waived for individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting. The FAQ indicated that this VBID did not cause the plan to fail to comply with the no cost-sharing preventive care requirements. A question about a different situation has been raised. Under a group health plan, similar preventive services are available both at an in-network ambulatory surgery center and at an in-network outpatient hospital setting, but currently no copayment is imposed for these services in either setting. This has been the case since March	guidance may be issued addressing other circumstances in which plan changes implementing those designs and programs may be made without relinquishing grandfather status.			

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	23, 2010. If this plan wished to adopt the VBID approach described in the example above by imposing a $250 copayment for these preventive services only when performed in the in-network outpatient hospital setting (i.e., not when performed in an in-network ambulatory surgery center), and with the same waiver of the copayment for any individuals for whom it would be medically inappropriate to have these preventive services provided in the ambulatory setting, would implementation of that new design now cause the plan to relinquish grandfather status?				
Affordable Care Act Implementation: Grandfathered Health Plans	**Q4:** A plan operating on a calendar plan year is considering an amendment to plan terms that will	**A4:** A plan or coverage will cease to be a grandfathered health plan when an amendment to plan terms, which exceeds the thresholds described in paragraph (g)(1) of the interim final	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html

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	exceed the thresholds described in paragraph (g)(1) of the interim final regulations and cause it to relinquish grandfather status. If the plan sponsor decides to adopt this amendment on July 1, 2011, and the change becomes effective for the plan year beginning on January 1, 2012, at what point in time does the plan relinquish grandfather status?	regulations, becomes effective – regardless of when the amendment is adopted. Therefore, in this example, the plan would cease to be a grandfathered health plan on January 1, 2012, the first day of the first plan year for which the change is effective.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q5:** A plan operating on a calendar plan year is considering an amendment to plan terms that will cause it to relinquish grandfather status, but wants the amendment to become effective before the first day of the next plan year. If the plan sponsor decides to make this amendment effective on July 1, 2011, does	**A5:** Yes. A plan or coverage will cease to be a grandfathered health plan when a plan amendment becomes effective. Therefore, if a plan sponsor chooses to make an amendment to plan terms effective in the middle of a plan year, the plan will cease to be a grandfathered health plan at that time. If a plan sponsor wishes to avoid relinquishing grandfathered status in the middle of a plan year, any changes that will cause a plan or coverage to relinquish grandfather status should be made effective the first day of a plan year that begins after the change is	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html

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	the plan relinquish grandfather status in the middle of the plan year?	adopted.			
Affordable Care Act Implementation: Grandfathered Health Plans	**Q6:** A plan covers both retirees and active employees and is subject to the market reform requirements of the Affordable Care Act. For retirees, the employer that sponsors the plan contributes $300 per year multiplied by the individual's years of service for the employer, capped at $10,000 per year. As the cost of coverage increases over time, how is it determined whether the employer's contribution rate has decreased for purposes of maintaining grandfather status?	**A6:** In this example, the employer makes contributions based on a formula. Accordingly, the plan will cease to be a grandfathered health plan if the employer decreases its contribution rate towards the cost of coverage by more than five percent below the contribution rate on March 23, 2010. If the formula does not change, the employer is not considered to have reduced its contribution rate, regardless of any increase in the total cost of coverage. However, if the dollar amount that is multiplied by years of service decreases by more than five percent (or if the $10,000 maximum employer contribution cap decreases by more than five percent), the plan will cease to be a grandfathered health plan.	FAQ Part VI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca6.html
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q7:** My plan already provided an external review process before the Affordable	**A7:** If your plan existed prior to enactment of the Affordable Care Act, you should first check to see if your plan is a grandfathered health plan. If it	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	Care Act was enacted. Can my already-existing external review process be deemed to comply with Public Health Service Act (PHS Act) section 2719(b)?	is, the new external review provisions of PHS Act section 2719(b) do not apply to your plan. If your plan is not a grandfathered health plan and it is insured, the Departments have provided transitional relief under which plans can use existing State external processes, in one of the States in which they operate, to comply with the new Federal requirements. This transitional relief applies regardless of whether the plan already existed on March 23, 2010 or is a new plan . If your plan is not a grandfathered health plan and it is self-insured, relief is also provided. On August 23, 2010, the Department of Labor issued Technical Release 2010-01, which sets forth an enforcement safe harbor. If the plan complies with one of the methods set forth in the release, the Department of Labor and the IRS will not take any enforcement action with respect to PHS Act section 2719(b) during the transition period. See also Q&A8, below.			
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q8:** What if a self-insured plan's external review process does not satisfy the safe harbor in the DOL technical release?	**A8:** The technical release provides a safe harbor from enforcement by the Departments. For plans that do not strictly comply with all the standards set forth in the technical release, compliance will be determined on a case-by-case basis under a facts and	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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		circumstances analysis. Thus, a plan that does not satisfy all of the standards of the technical release's safe harbor may in some circumstances nonetheless be considered to be in compliance with PHS Act section 2719(b). For example, one of the standards set forth in the technical release requires self-insured plans to contract with at least three independent review organizations (IROs) and to rotate claims assignments among them (or to incorporate other independent, unbiased methods for selection of IROs, such as random selection). However, a self-insured group health plan's failure to contract with at least three IROs does not mean that the plan has automatically violated PHS Act section 2719(b). Instead, a plan may demonstrate other steps taken to ensure that its external review process is independent and without bias.			
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q9:** Similarly, what if a self-insured plan does not contract directly with any independent review organization (IRO), but contracts with a third-party administrator (TPA) that, in turn, contracts with an	**A9:** The technical release does not require a plan to contract directly with any IRO. Where a self-insured plan contracts with a TPA that, in turn, contracts with an IRO, the standards of the technical release can be satisfied in the same manner as if the plan had contracted directly. Of course, such a contract does not automatically relieve the plan from responsibility if there is a failure to provide an individual with	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	IRO?	external review. Moreover, fiduciaries of plans that are subject to ERISA have a duty to monitor the service providers to the plan.			
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q10:** What if there is no IRO in my plan's State?	**A10:** The IRO is not required to be in the same State as the plan. Plans may contract with an IRO even if it is located in another State.	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q11:** The Departments' regulations make changes to shorten the times for making initial determinations with respect to urgent care claims, but did not make any changes to the times for making internal appeals decisions. The Departments' model notice of adverse benefit determination issued on August 23, 2010, was unclear as to which times have been shortened. What is the rule?	**A11:** Only the times for making the initial benefit determination were changed. The Departments have revised the model notice to eliminate confusion. The revised notice includes a header that reads, "Revised as of September 20, 2010".	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q12:** I anticipate that my plan will no longer be a grandfathered plan and will have a hard	**A12**: Yes, on September 20, 2010 the Department of Labor issued Technical Release 2010-02 at www.dol.gov/ebsa/newsroom/tr10-02.html providing an enforcement grace	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	time making systems changes in time to comply with some of the new standards for claims and internal appeals. Is there any relief?	period until July 1, 2011 to give plans and issuers necessary time to make certain procedural and computer system changes to comply with the new requirements.			
Affordable Care Act Implementation: Claims, Internal Appeals, and External Review	**Q13:** The September 20, 2010 technical release, among other things, gives plans and issuers additional time (as an enforcement grace period until July 1, 2011) before they have to provide new content (such as coding information) on notices of adverse benefit determination and notices of final adverse benefit determination. Does this mean that notices are not required during the grace period?	**A13:** No. The Technical Release 2010-02 provides that the standards of the Department of Labor's claims procedure regulation issued on November 21, 2000 (29 CFR 2560.503-1) apply. A grace period is given only for the new content required under paragraph (b)(2)(ii)(E) of the Departments' July 23, 2010 interim final claims and appeals regulations. In addition, under existing regulations, claimants may obtain coding and other information relevant to the claimant's claim for benefits free of charge upon request. See 29 CFR 2560.503-1(h)(2)(iii).	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html
Affordable Care Act Implementation: Dependent Coverage of Children to Age 26	**Q14:** Will a group health plan or issuer fail to satisfy section 2714 of the Public Health Service Act (PHS Act) and its	**A14:** No. A plan or issuer does not fail to satisfy the requirements of PHS Act section 2714 or its implementing regulations because the plan limits health coverage for children until the child turns 26 to only those children	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	implementing interim final regulations merely because it conditions health coverage on support, residency, or other dependency factors for individuals under age 26 who are not described in section 152(f)(1) of the Internal Revenue Code (Code)? (That section of the Code defines children to include only sons, daughters, stepchildren, adopted children (including children place for adoption), and foster children.)	who are described in section 152(f)(1) of the Code. For an individual not described in Code section 152(f)(1), such as a grandchild or niece, a plan may impose additional conditions on eligibility for health coverage, such as a condition that the individual be a dependent for income tax purposes.			
Affordable Care Act Implementation: Dependent Coverage of Children to Age 26	**Q5:** My group health plan normally charges a copayment for physician visits that do not constitute preventive services. The plan charges this copayment to individuals age 19 and over, including employees, spouses,	**A5:** Yes. The Departments' regulations implementing PHS Act section 2714 provide that the terms of a group health plan or health insurance coverage providing dependent coverage of children cannot vary based on age (except for children who are age 26 or older). While this generally prohibits distinctions based upon age in dependent coverage of children, it does not prohibit distinctions based upon age	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	and dependent children, but waives it for those under age 19. Is this permissible?	that apply to all coverage under the plan, including coverage for employees and spouses as well as dependent children. In this case, the copayments charged to dependent children are the same as those charged to employees and spouses. Accordingly, the Departments will not consider the arrangement described in this question (including waiver, for individuals under age 19, of the generally applicable copayment) to violate PHS Act section 2714 or its implementing regulations.			
Affordable Care Act Implementation: Out-of-Network Emergency Services	**Q15:** Public Health Service Act (PHS Act) section 2719A generally provides, among other things, that if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect	**A15:** Are the minimum payment standards in paragraph (b)(3) of the regulations intended to apply in circumstances where State law prohibits balance billing? (Similarly, what if a plan or issuer is contractually obligated to bear the cost of any amounts balance billed, so that the patient is held harmless from those costs?) No. As stated in the preamble to the interim final regulations under section 2719A, the minimum payment standards set forth in paragraph (b)(3) of the regulations were developed to protect patients from being financially penalized for obtaining emergency services on an out-of-network basis. If a State law prohibits balance billing, plans and issuers are not required to satisfy the payment minimums set forth in the	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network. At the same time, the statute does not require plans or issuers to cover amounts that out-of-network providers may "balance bill". Accordingly, the interim final regulations under section 2719A set forth minimum payment standards in paragraph (b)(3) to ensure that a plan or issuer does not pay an unreasonably low amount to an out-of-network emergency service provider who, in turn, could simply balance bill the patient.	regulations. Similarly, if a plan or issuer is contractually responsible for any amounts balance billed by an out-of-network emergency services provider, the plan or issuer is not required to satisfy the payment minimums. In both situations, however, patients must be provided with adequate and prominent notice of their lack of financial responsibility with respect to such amounts, to prevent inadvertent payment by the patient. Nonetheless, even if State law prohibits balance billing, or if the plan or issuer is contractually responsible for amounts balance billed, the plan or issuer may not impose any copayment or coinsurance requirement that is higher than the copayment or coinsurance requirement that would apply if the services were provided in network.			
Affordable Care Act Implementation: Highly Compensated Employees	**Q16:** Are the Departments planning to issue any	**A16:** Yes, on September 20, 2010 the Internal Revenue Service released Notice 2010-63, to be published in	FAQ Part I	DOL	http://www.dol.gov/ebsa/faqs/faq-aca.html

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	guidance regarding the provisions of Public Health Service Act (PHS Act) section 2716 (which prohibits discrimination in favor of highly compensated individuals in insured group health plans)?	Internal Revenue Bulletin 2010-41, October 12, 2010. This bulletin provides background information on the statutory provisions of PHS Act section 2716 that has been reviewed and approved by the three Departments. In addition, it invites comments to be considered in the development of future guidance.			
Affordable Care Act Implementation: Dental and Vision Benefits	**Q6:** What if my dental (or vision) benefits are structured as excepted benefits under HIPAA? Does that exemption except my dental (or vision) plan from the Affordable Care Act's market reforms?	**A6:** Yes. If benefits constitute excepted benefits under HIPAA, the requirements of the Affordable Care Act's market reforms do not apply. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they: Are offered under a separate policy, certificate, or contract of insurance; or Are not an integral part of the plan. For dental (or vision) benefits to be considered not an integral part of the plan (whether insured or self-insured), participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium. Accordingly, if a plan provides its dental (or vision) benefits pursuant to a separate election by a participant and the plan charges even a nominal employee contribution towards the coverage, the dental (or vision) benefits would constitute excepted benefits, and	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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		the market reform provisions would not apply to that coverage.			
Affordable Care Act Implementation: Rescissions	**Q7:** The Affordable Care Act (through Public Health Service Act section 2712) generally provides that plans and issuers must not rescind coverage unless there is fraud or an individual makes an intentional misrepresentation of material fact. A rescission is defined as it is commonly understood under the law – a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent attributable to a failure to pay timely premiums towards coverage. Is the exception to the statutory ban on rescission limited to fraudulent or intentional misrepresentations about prior medical history? What about	**A7:** The statutory prohibition related to rescissions is not limited to rescissions based on fraudulent or intentional misrepresentations about prior medical history. An example in the Departments' interim final regulations on rescissions clarifies that some plan errors (such as mistakenly covering a part-time employee and providing coverage upon which the employee relies for some time) may be cancelled prospectively once identified, but not retroactively rescinded unless there was some fraud or intentional misrepresentation by the employee. On the other hand, some plans and issuers have commented that some employers' human resource departments may reconcile lists of eligible individuals with their plan or issuer via data feed only once per month. If a plan covers only active employees (subject to the COBRA continuation coverage provisions) and an employee pays no premiums for coverage after termination of employment, the Departments do not consider the retroactive elimination of coverage back to the date of termination of employment, due to delay in administrative record-keeping, to be a rescission.	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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	retroactive terminations of coverage in the "normal course of business"?	Similarly, if a plan does not cover ex-spouses (subject to the COBRA continuation coverage provisions) and the plan is not notified of a divorce and the full COBRA premium is not paid by the employee or ex-spouse for coverage, the Departments do not consider a plan's termination of coverage retroactive to the divorce to be a rescission of coverage. (Of course, in such situations COBRA may require coverage to be offered for up to 36 months if the COBRA applicable premium is paid by the qualified beneficiary.)			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q8:** Some of the recommendations and guidelines of the United States Preventive Services Task Force (USPTF), the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) and the Health Resources and Services Administration (HRSA) do not definitively state the	**A8:** The interim final regulations regarding preventive health services provide that if a recommendation or guideline for a recommended preventive health service does not specify the frequency, method, treatment, or setting for the provision of that service, the plan or issuer can use reasonable medical management techniques (which generally limit or exclude benefits based on medical necessity or medical appropriateness using prior authorization requirements, concurrent review, or similar practices) to determine any coverage limitations under the plan. Thus, to the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant evidence base and these	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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	scope, setting, or frequency of the items or services to be covered. What should my plan do if an individual requests, for example, daily counseling for diet?	established techniques to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service.			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q3:** My plan does not have any in-network providers to provide a particular preventive service required under PHS Act section 2713. If I obtain this service out-of-network, can the plan impose cost-sharing?	**A3:** No. While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q4:** The USPSTF recommends the use of aspirin for certain men and women when the potential benefit due to a reduction in myocardial infarctions outweighs	**A4:** Aspirin and other OTC recommended items and services must be covered without cost-sharing only when prescribed by a health care provider.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	the potential harm. Aspirin is generally available over-the-counter (OTC) to patients. Are group health plans and health insurance issuers now required to pay for OTC methods such as aspirin? (United States Preventive Services Task Force = USPSTF)				
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q5:** If a colonoscopy is scheduled and performed as a screening procedure pursuant to the USPSTF recommendation, is it permissible for a plan or issuer to impose cost-sharing for the cost of a polyp removal during the colonoscopy?	**A5:** No. Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act	**Q6:** Does the	**A6:** Yes. HHS believes that the scope of	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Preventive Health Services and Coverage of Preventive Health Services	recommendation for genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing include the BRCA test itself?	the recommendation includes both genetic counseling and BRCA testing, if appropriate, for a woman as determined by her health care provider. PHS Act section 2713 addresses coverage for evidence-based items or services with a rating of "A" or "B" in the current recommendations of the USPSTF, as well as coverage for preventive care and screenings as provided for in comprehensive guidelines released by HRSA. The USPSTF recommends with a "B" rating that "women whose family history is associated with an increased risk for deleterious mutations in the BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing." The HRSA Guidelines, released by HHS in August 2011, incorporate by reference relevant portions of an Institute of Medicine (IOM) Report, released on July 19, 2011. In some instances, the IOM Committee Report provides additional interpretation of USPSTF recommendations. For the USPSTF BRCA recommendation, the IOM Committee interpreted the recommendation to include "referral for genetic counseling and BRCA testing, if appropriate." Thus, genetic counseling and BRCA testing, if appropriate, must			aca12.html

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		be made available as a preventive service without cost-sharing.			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q7:** Some USPSTF recommendations apply to certain populations identified as high-risk. Some individuals, for example, are at increased risk for certain diseases because they have a family or personal history of the disease. It is not clear, however, how a plan or issuer would identify individuals who belong to a high-risk population. How can a plan or issuer determine when a service should or should not be covered without cost-sharing?	**A7:** Identification of "high-risk" individuals is determined by clinical expertise. Decisions regarding whether an individual is part of a high-risk population, and should therefore receive a specific preventive item or service identified for those at high-risk, should be made by the attending provider. Therefore, if the attending provider determines that a patient belongs to a high-risk population and a USPSTF recommendation applies to that high-risk population, that service is required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q8:** Which ACIP recommendations are required to be covered without cost-sharing by non-grandfathered group	**A8:** PHS Act section 2713 and the interim final regulations require coverage for immunizations for routine use in children, adolescents, and adults that have in effect a recommendation by the ACIP for routine use. The vaccines	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	health plans and health insurance coverage? (Advisory Committee on Immunization Practices = ACIP)	must be covered without cost-sharing requirements when the service is delivered by an in-network provider. The ACIP makes routine immunization recommendations for children, adolescents, and adults that are population-based (e.g., age-based), risk-based (e.g., underlying medical conditions, work-related, or other special circumstances that increase risk of illness), or are catch-up recommendations. In some circumstances, the ACIP makes a recommendation that applies for certain individuals rather than an entire population. In these circumstances, health care providers should determine whether the vaccine should be administered, and if the vaccine is prescribed by a health care provider consistent with the ACIP recommendations, a plan or issuer is required to provide coverage for the vaccine without cost-sharing. New ACIP recommendations will be required to be covered without cost-sharing starting with the plan year (in the individual market, policy year) that begins on or after the date that is one year after the date the recommendation is issued. An ACIP recommendation is considered to be issued on the date on which it is adopted by the Director of			

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		the Centers for Disease Control and Prevention (CDC), which is the earlier of: the date the recommendation is published in the Mortality and Morbidity Weekly Report, or the date the recommendation is reflected in the Immunization Schedules of the CDC. Therefore plans or issuers with respect to a plan can determine annually what vaccines recommended by ACIP must be covered by checking http://www.healthcare.gov/law/features/rights/preventive-care/index.html prior to the beginning of each plan year.			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q9:** Do the recommendations for women's preventive services in the HRSA Guidelines promote multiple visits for separate services?	**A9:** No. Section 2713 of the PHS Act and its implementing regulations allow plans and issuers to use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent this information is not specified in a recommendation or guideline. Although the HRSA Guidelines list services individually, nothing in PHS Act section 2713 or the regulations requires that each service be provided in a separate visit. Efficient care delivery and the delivery of multiple prevention and screening services at a single visit is a reasonable medical management technique, permissible under the regulations. For example, HIV screening and counseling and Sexually Transmitted Infections counseling could	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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		occur as part of a single well-woman visit.			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q10:** What is included in a "well-woman" visit?	**A10:** The HRSA Guidelines recommend at least one annual well-woman preventive care visit for adult women to obtain the recommended preventive services that are age- and developmentally-appropriate, including preconception and prenatal care. The HRSA Guidelines recommend that well-woman visits include preventive services listed in the HRSA Guidelines, as well as others referenced in section 2713 of the PHS Act. HHS understands that additional well-woman visits, provided without cost-sharing, may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors. If the clinician determines that a patient requires additional well-woman visits for this purpose, then the additional visits must be provided in accordance with the requirements of the interim final regulations (that is, without cost-sharing and subject to reasonable medical management).	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q11:** What do health care providers need to know to conduct a screening and counseling for interpersonal and	**A11:** Screening may consist of a few, brief, open-ended questions. Screening can be facilitated by the use of brochures, forms, or other assessment tools including chart prompts. One option is the five-question Abuse	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	domestic violence, as recommended in the HRSA Guidelines?	Assessment Screening tool available here: (http://www.cdc.gov/ncipc/pub-res/images/ipvandsvscreening.pdf, page 22). Counseling provides basic information, including how a patient's health concerns may relate to violence and referrals to local domestic violence support agencies when patients disclose abuse. Easy-to-use tools such as patient brochures, safety plans, and provider educational tools, as well as training materials, are available through the HHS-funded Domestic Violence Resource Network, including the National Resource Center on Domestic Violence (http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services/programs/centers).			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q12:** In the discussion of "Identified Gaps" within the Cervical Cancer section of the IOM report, the IOM recognized "co-testing with cytology and high-risk Human Papillomavirus (HPV) DNA testing among women 30 years of age and older as a strategy to increase screening intervals to every	**A12:** The HRSA Guidelines recommend high-risk HPV DNA testing for women with normal cytology results who are 30 years of age or older to occur no more frequently than every 3 years.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	three years." When should the HPV DNA test be administered?				
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q13:** The HRSA Guidelines include a recommendation for annual HIV counseling and screening for all sexually active women. Is the term "screening" in this context defined as actual testing for HIV?	**A13:** Yes. In this context, "screening" means testing.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q14:** The HRSA Guidelines include a recommendation for all Food and Drug Administration (FDA) approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider. May a plan or issuer cover only oral	**A14:** No. The HRSA Guidelines ensure women's access to the full range of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. Consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans may cover a generic drug without cost-sharing and impose cost-sharing for equivalent branded drugs. However, in these instances, a plan or issuer must accommodate any	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	contraceptives?	individual for whom the generic drug (or a brand name drug) would be medically inappropriate, as determined by the individual's health care provider, by having a mechanism for waiving the otherwise applicable cost-sharing for the branded or non-preferred brand version. This generic substitution approach is permissible for other pharmacy products, as long as the accommodation described above exists.[9] If, however, a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q15:** Do the HRSA Guidelines include contraceptive methods that are generally available over-the-counter (OTC), such as contraceptive sponges and spermicides?	**A15:** Contraceptive methods that are generally available OTC are only included if the method is both FDA-approved and prescribed for a woman by her health care provider. The HRSA Guidelines do not include contraception for men.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act	**Q16:** Do the HRSA	**A16:** Yes. Services related to follow-up	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Preventive Health Services and Coverage of Preventive Health Services	Guidelines include services related to follow-up and management of side effects, counseling for continued adherence, and for device removal?	and management of side effects, counseling for continued adherence, and device removal are included under the HRSA Guidelines and required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management).			aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q17:** Are intrauterine devices and implants contraceptive methods under the HRSA Guidelines and therefore required to be covered without cost-sharing?	**A17:** Yes, if approved by the FDA and prescribed for a woman by her health care provider, subject to reasonable medical management.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q18:** The USPSTF already recommends breastfeeding counseling. Why is this part of the HRSA Guidelines?	**A18:** Under the topic of "Breastfeeding Counseling" the USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding. The HRSA Guidelines specifically incorporate comprehensive prenatal and postnatal lactation support, counseling, and equipment rental. Accordingly, the items and services described in the HRSA Guidelines are required to be covered in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management, which may include	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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		purchase instead of rental of equipment).			
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q19:** How are certified lactation consultants reimbursed for their services under the HRSA Guidelines?	**A19:** Reimbursement policy is outside of the scope of the HRSA Guidelines and the Departments' regulations.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Preventive Health Services and Coverage of Preventive Health Services	**Q20:** Under the HRSA Guidelines, how long after childbirth is a woman eligible for lactation counseling? Are breastfeeding equipment and supplies unlimited?	**A20:** Coverage of comprehensive lactation support and counseling and costs of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding. Nonetheless, consistent with PHS Act section 2713 and its implementing regulations, plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive item or service, to the extent not specified in the recommendation or guideline.	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html
Affordable Care Act Implementation: Clarification Relating to Policy Year and Effective Date of the ACA for Indv. Health Insurance Policies	**Q9:** Some States and issuers have interpreted the definition of a policy year in the interim final regulation on dependent coverage of children to age 26(4) to mean that if an issuer establishes a policy year for the insured under an	**A9:** No. We understand that carriers in the health insurance individual market may designate a fixed policy year, but continue to issue policies throughout the year. For example, a carrier may designate a policy year of January 1 through December 31 for an individual policy under which coverage begins on October 1. However, the statute and regulations contemplate implementation of the	FAQ Part II	DOL	http://www.dol.gov/ebsa/faqs/faq-aca2.html

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	individual policy on a basis other than the effective date of coverage (such as a calendar year beginning January 1, 2012), then the provisions of the Affordable Care Act do not apply to those policies before the start of the policy year. Can compliance with the Affordable Care Act requirements for policies in the individual market sold on or after September 23, 2010 be effective on a date other than the date that coverage begins?	Affordable Care Act requirements at the beginning of the first new period of coverage that begins on or after September 23, 2010, whether this new coverage period is a full or shortened period of coverage. If a policy begins to cover an individual effective on a date that is on or after September 23, 2010, the initial policy year for that individual, for purposes of determining the effective date of the Affordable Care Act requirements, begins on the first date on which the coverage is effective. This initial period of coverage might be an abbreviated policy year. For example, it may run from October 1, 2010 through December 31, 2010, with a new calendar-based policy year beginning on January 1, 2011 (assuming the individual renews the policy), or from December 1, 2010 through June 30, 2011, with a new policy year beginning each July 1 (again, assuming the policy is renewed). It would be a "policy year" for purposes of the Affordable Care Act effective date if it is a new period of coverage, regardless of when (or whether) the first subsequent 12 month policy year begins. If issuers, however, have relied in good faith on guidance or instructions from a state insurance regulator indicating that the provisions of the Affordable Care			

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		Act are not applicable until the beginning of the first full policy year of the individual coverage, then carriers will be afforded a reasonable period of time after the issuance of this guidance to come into compliance with the law. Nonetheless, subsequent to the issuance of this guidance, issuers may not rely in good faith on any contrary guidance or instruction issued by a state insurance regulator.			
Affordable Care Act Implementation: Exemption for Group Health Plans with Less than Two Current Employees	**Q1:** Do the HIPAA statutory exemptions in effect since 1997 for group health plans with "less than two participants who are current employees" apply to the Affordable Care Act's group market reforms?	**A1:** Yes. The preamble to the interim final regulations on grandfathered plans1 noted that statutory provisions in effect since 1997 exempting group health plans with "less than two participants who are current employees" from HIPAA also exempt such plans from the group market reform requirements of the Affordable Care Act. Accordingly, under the terms of these statutory provisions, group health plans that do not cover at least two employees who are current employees (such as plans in which only retirees participate) are exempt from the Affordable Care Act's market reform requirements.	FAQ Part III	DOL	http://www.dol.gov/ebsa/faqs/faq-aca3.html
Affordable Care Act Implementation: Exemption for Group Health Plans with Less than Two Current Employees	**Q2:** I am an employer who sponsors a number of plans including one for both my retirees and individuals on	**A2:** The Departments have not issued guidance on this specific issue. In order to fully analyze the issue, and balance the goal of ensuring that the Affordable Care Act's market reforms and patient protections are provided to eligible	FAQ Part III	DOL	http://www.dol.gov/ebsa/faqs/faq-aca3.html

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	long-term disability. Before the Affordable Care Act, we treated our plan covering retirees and those on long-term disability as exempt under HIPAA. Can we continue to treat that plan as exempt?	enrollees of group health plans with the goal of preventing disruption of existing coverage, the Departments will be issuing a request for information (RFI) very soon. The RFI will solicit comments from employers and other stakeholders to inform future guidance. After reviewing the comments submitted, the Departments intend to publish guidance on this issue in 2011. Until guidance is issued, the Departments will treat plans described above as satisfying the exemption from HIPAA and the Affordable Care Act's group market reforms for plans with less than two participants who are current employees. To the extent future guidance on this issue is more restrictive with respect to the availability of the exemption than this interim relief, the guidance will be prospective, applying to plan years that begin some time after its issuance. Pending such further guidance, a plan may adopt any or all of the HIPAA and Affordable Care Act market reform requirements without prejudice to its exemption. The Departments encourage such voluntary compliance.			
Affordable Care Act Implementation: Value-Based Insurance Design in Connection with	**Q1:** My group health plan does not impose a copayment for colorectal cancer	**A1:** Yes, this plan design is permissible. PHS Act section 2713 and its implementing regulations allow plans to use reasonable medical management	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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Preventive Care Benefits	preventive services when performed in an in-network ambulatory surgery center. In contrast, the same preventive service provided at an in-network outpatient hospital setting would generally require a $250 copayment. Is this permissible under PHS Act section 2713?	techniques to control costs. The regulations the Departments issued to implement the preventive health benefits in the Affordable Care Act recognized the important role that VBID can play in promoting the use of appropriate, high value preventive services and providers. Plans may use reasonable medical management techniques to steer patients towards a particular high-value setting such as an ambulatory care setting for providing preventive care services, provided the plan accommodates any individuals for whom it would be medically inappropriate to have the preventive service provided in the ambulatory setting (as determined by the attending provider) by having a mechanism for waiving the otherwise applicable copayment for the preventive services provided in a hospital.			
Affordable Care Act Implementation: Automatic Enrollment in Health Plans	**Q2:** The Affordable Care Act amended the Fair Labor Standards Act (FLSA) by adding a new section 18A, requiring employers with more than 200 full-time employees to automatically enroll new full-time employees in the employer's health	**A2:** The Secretary of Labor has delegated responsibility for FLSA section 18A rulemaking, and for regulations under new section 18B of the FLSA, Notice to Employees of Coverage Options, to the Employee Benefits Security Administration (EBSA) within the Department of Labor. EBSA and the Department of the Treasury will coordinate to develop the rules that will apply in determining full-time employee status for purposes of the amendments to the FLSA and the	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	benefits plans and continue enrollment of current employees. What Agency is responsible for guidance under this new FLSA provision?	rulemaking by the Treasury Department under the Internal Revenue Code to develop the rules that will apply in determining full-time employee status for purposes of the amendments made by the Affordable Care Act to the Internal Revenue Code.			
Affordable Care Act Implementation: Automatic Enrollment in Health Plans	**Q3:** When do employers have to comply with the new automatic enrollment requirements in section 18A of the FLSA?	**A3:** Section 18A provides that employer compliance with the automatic enrollment provisions of that section shall be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]." Accordingly, it is the view of the Department of Labor that, until such regulations are issued, employers are not required to comply with section 18A. The Department of Labor expects to work with stakeholders to ensure that it has the necessary information and data it needs to develop regulations in this area that take into account the practices employers currently use for auto-enrollment and to solicit the views and practices of a broad range of stakeholders, including employers, workers, and their families. The Department of Labor intends to complete this rulemaking by 2014.	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html
Affordable Care Act Implementation: Disclosure under PHS Act Secion 2715(d)(4)	**Q4:** When are group health plans and health insurance issuers required to	**A4:** PHS Act section 2715 as added by the Affordable Care Act generally provides, among other things, that not later than 12 months after the date of	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	comply with the notice requirement in PHS Act section 2715 (d)(4), which generally requires a 60-day prior notice for material modifications to the plan or coverage?	enactment of the Affordable Care Act, the Departments must develop standards for use by group health plans and health insurance issuers in compiling and providing a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage and, not later than 24 months after the date of enactment, plans and issuers must begin to provide the summary pursuant to the standards. PHS Act section 2715(d)(4) generally provides that if a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage involved (as defined for purposes of section 102 of the Employee Retirement Income Security Act (ERISA)) that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer must provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective. Accordingly, it is the view of the Departments that group health plans and health insurance issuers are not required to comply with the 60-day prior notice requirement for material modifications in PHS Act section 2715 (d)(4) until			

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		plans and issuers are required to provide the summary of benefits and coverage explanation pursuant to the standards issued by the Departments.(1) The Departments have not yet issued the standards.			
Affordable Care Act Implementation: Preexisting Condition Exclusions for Children in the Individual Market	**Q6:** Some States have expressed an interest in permitting issuers to screen applicants for eligibility for alternative coverage options before offering a child-only policy. Is this allowed?	**A6:** Yes, under certain circumstances, issuers may screen applicants for eligibility for alternative coverage options before offering a child-only policy, provided this practice is permitted under State law. Screening is limited to circumstances in which all child-only applicants, regardless of health status, undergo the same screening process, and the alternative coverage options include options for which healthy children would potentially be eligible, such as the Children's Health Insurance Program (CHIP) and group health insurance. Screening may not be limited to programs targeted to individuals with a pre-existing condition, such as the state high risk pool or Pre-existing Condition Insurance Plan (PCIP). Note that Medicaid policy, under 42 U.S.C.A. § 1396a (25)(G), prohibits participating States from allowing health issuers to consider whether an individual is eligible for, or is provided medical assistance under, Medicaid in making enrollment decisions. Furthermore, issuers may not implement a screening	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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		process that by its operation significantly delays enrollment or artificially engineers eligibility of a child for a program targeted to individuals with a pre-existing condition. Additionally, the screening process may not be applied to offers of dependent coverage for children given the new Affordable Care Act requirement of offering coverage to dependents up to age 26. States are encouraged, subject to State law, to require issuers that screen for other coverage to enroll and provide coverage to the applicant effective on the first date that the child-only policy would have been effective had the applicant not been screened for an alternative coverage option. States are also encouraged to impose a reasonable time limit, such as 30 days, at which time the issuer would have to enroll the child regardless of pending applications for other coverage. Finally, nothing in this FAQ should be construed to relieve the issuer of its obligation to enroll a child applicant in coverage.			
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q8:** After the amendments made by the Affordable Care Act, are small employers still	**A8:** Yes, small employers are still exempt. Although there were changes to the definition of "small employer" for other purposes under the Affordable Care Act, ERISA and the Code continue	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	exempt from the MHPAEA requirements? How is "small employer" defined?	to define a small employer as one that has 50 or fewer employees. Accordingly, for group health plans and health insurance issuers subject to ERISA and the Code, the Departments will continue to treat group health plans of employers with 50 or fewer employees as exempt from the MHPAEA requirements under the small employer exemption, regardless of any State insurance law definition of small employer. For nonfederal governmental plans, the PHS Act was amended by the Affordable Care Act to define a small employer as one that has 100 or fewer employees.			
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q9:** I am an in-network health care provider and one of my patients is having trouble getting benefits paid for a mental health condition or substance use disorder. Am I entitled to receive a copy of the criteria for medical necessity determinations made by the patient's plan or health insurance coverage?	**A9:** Yes. MHPAEA and its implementing regulations state that the criteria for medical necessity determinations made under a plan or health insurance coverage with respect to mental health or substance use disorder benefits must be made available by the plan administrator or health insurance issuer to any current or potential participant, beneficiary, or contracting provider upon request.	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html
	Q10: I was denied	**A10:** Under ERISA, documents with	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-

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	benefits for mental health treatment by my plan because the plan determined that the treatment was not medically necessary. I requested and received a copy of the criteria for medical necessity determinations for mental health and substance use disorder treatment, and the reason for denial. I think my plan is applying medical necessity standards more strictly to benefits for mental health and substance use disorder treatment than for medical/surgical benefits. How can I obtain information on the medical necessity criteria used for medical/surgical benefits?	information on the medical necessity criteria for both medical/surgical benefits and mental health/substance use disorder benefits are plan documents, and copies of plan documents must be furnished within 30 days of your request. See ERISA regulations at 29 CFR 2520.104b-1. Additionally, if a provider or other individual is acting as a patient's authorized representative in accordance with the Department of Labor's claims procedure regulations at 29 CFR 2560.503-1, the provider or other authorized representative may request these documents. If your plan is not subject to ERISA (for example, a plan maintained by a State or local government), you should check with your plan administrator.			aca5.html
Affordable Care Act Implementation: The Mental Health Parity and	**Q11:** MHPAEA contains an increased cost exemption. How	**A11:** MHPAEA contains an increased cost exemption that is available for plans that make changes to comply with	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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Addiction Equity Act of 2008	does a plan claim this exemption?	the law and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan (the first plan year beginning after October 3, 2009) or at least one percent in any subsequent plan year (generally, plan years beginning after October 3, 2010). If such a cost is incurred, the plan is exempt for the plan year following the year the cost was incurred. Thus, the exemption lasts one year. After that, the plan is required to comply again; however, if the plan incurs an increased cost of at least one percent in that plan year, the plan could claim the exemption for the following plan year. The Departments' interim final regulations implementing MHPAEA did not provide guidance for implementing the increased cost exemption. Accordingly, during an interim enforcement safe harbor until future regulatory guidance is effective, a plan that has incurred an increased cost of two percent during its first year of compliance can obtain an exemption for the second plan year by following the exemption procedures described in the Departments' 1997 MHPA regulations (62 FR 66932, December 22, 1997)(4), except that, as required under MHPAEA, for the first year of compliance the applicable percentage of increased cost is two percent and the			

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		exemption lasts only one year. Calculations of increased costs due to MHPAEA should include increases in a plan's share of cost sharing. Moreover, any non-recurring administrative costs (such as adjustments to computer software) attributable to complying with MHPAEA must be appropriately amortized. Plans applying for an exemption must demonstrate that increases in cost are attributable directly to implementation of MHPAEA and not otherwise to occurring trends in utilization and prices, a random claims experience that is unlikely to persist, or seasonal variation typically experienced in claims submission and payment patterns.			
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q2:** For all mental health and substance use disorder benefits, my group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary, but the plan does not require such prior authorization for any medical/surgical benefits. Is this permissible?	**A2:** No. The plan is applying a nonquantitative treatment limitation to mental health and substance use disorder benefits that is not applied to medical/surgical benefits. This violates MHPAEA's prohibition on separate treatment limitations that are applicable only to mental health or substance use disorder benefits.	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

ALL ACA-RELATED FEDERAL FAQs AS OF October 9, 2013
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Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q3:** My group health plan requires prior authorization from the plan's utilization reviewer that a treatment is medically necessary for all inpatient medical/surgical benefits and for all inpatient mental health and substance use disorder benefits. In practice, inpatient benefits for medical/surgical conditions are routinely approved for seven days, after which a treatment plan must be submitted by the patient's attending provider and approved by the plan. On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given for only one day, after which a treatment plan must be submitted by the patient's attending	**A3:** No. The plan is applying a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits. While some differences in prior authorization practices with respect to individual conditions or treatments might be permissible based on recognized clinically appropriate standards of care, the interim final regulations do not permit a plan to apply stricter nonquantitative treatment limitations to all benefits for mental health or substance use disorders than those applied to all medical/surgical benefits. The application of nonquantitative treatment limitations -- both with respect to the plan's benefits and its care management practices -- must comply with the nonquantitative treatment limitation rules.	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

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	provider and approved by the plan. Is this permissible?				
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q4:** My group health plan considers a wide array of factors in designing medical management techniques for both mental health/substance use disorder benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these factors in a comparable fashion, prior authorization is	**A4:** Yes. It appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

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	required for some (but not all) mental health and substance use disorder benefits, as well as for some medical/surgical benefits, but not for others. For example, under my plan, prior authorization is required for: outpatient surgery; speech, occupational, physical, cognitive and behavioral therapy extending for more than six months; durable medical equipment; diagnostic imaging; skilled nursing visits; home infusion therapy; coordinated home care; pain management; high-risk prenatal care; delivery by cesarean section; mastectomy; prostate cancer treatment; narcotics prescribed for more than seven days; and all inpatient services beyond 30 days. The				

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	evidence considered in developing its medical management techniques includes consideration of a wide array of recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials). This evidence and how it was used to develop these medical management techniques is also well documented. Has my plan complied with the nonquantitative treatment limitation rules?				
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q5:** I am an employer considering several health insurance policy options. One health insurance policy requires prior authorization for all outpatient mental health benefits but	**A5:** While some differences in plan requirements for prior authorization might be permissible based on recognized clinically appropriate standards of care, it is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

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	only a few types of outpatient medical/surgical benefits (outpatient surgery; speech, occupational and physical therapy; and skilled home nursing visits.) Is this permissible?	authorization would also result in all outpatient mental health and substance use disorder outpatient benefits needing prior authorization.			
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q6:** A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8). In practice, the application of this standard affects 60 percent of mental health conditions and substance use disorder conditions, but only 30 percent of medical/surgical conditions. Is this permissible?	**A6:** Yes. The evidentiary standard used by the plan is applied no more stringently for mental health and substance use disorder benefits than for medical/surgical benefits, even though it results in an overall difference in the application of concurrent review for mental health conditions or substance use disorders than for medical/surgical conditions.	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html
Affordable Care Act Implementation: The Mental Health Parity and Addiction Equity Act of 2008	**Q7:** Is my group health plan always limited in the amount that it can charge for all mental	**A7:** No. The standard for determining the maximum copayment that can be applied to mental health/substance use disorder benefits is determined by the predominant copayment that applies to	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

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	health/substance use disorder providers to the same rate as medical/surgical generalists?	substantially all medical/surgical benefits within a classification. If the copayment that meets this standard is the one charged for a medical/surgical specialist, that copayment can be charged for all mental health/substance use disorder benefits within that classification. On the other hand, if the copayment that meets this standard is the one charged for a medical/surgical generalist, then that is the copayment that can be charged to all mental health/substance use disorder benefits within that classification.			
Affordable Care Act Implementation: Nondiscrimination Based on a Health Factor and Wellness Programs	**Q12:** Are all employment-based wellness programs required to check for compliance with the HIPAA nondiscrimination provisions?	**A12:** No. Many employers offer a wide range of programs to promote health and prevent disease. For example, some employers may choose to provide or subsidize healthier food choices in the employee cafeteria, provide pedometers to encourage employee walking and exercise, pay for gym memberships, or ban smoking on employer facilities and campuses. A wellness program is subject to the HIPAA nondiscrimination rules only if it is, or is part of, a group health plan. If an employer operates a wellness program as an employment policy separate from its group health plan(s), the program may be covered by other Federal or State nondiscrimination laws, but it is not subject to the HIPAA nondiscrimination regulations.	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html
Affordable Care Act	**Q13:** My group	**A13:** No. This wellness program is not	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Nondiscrimination Based on a Health Factor and Wellness Programs	health plan gives an annual premium discount of 50 percent of the cost of employee-only coverage to participants who adhere to a wellness program which consists of attending a monthly health seminar. Does this reward violate the HIPAA nondiscrimination regulations?	based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five criteria (set forth above) in the HIPAA nondiscrimination regulations. (The rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage applies only to programs that require satisfaction of a standard related to a health factor in order to qualify for the reward.)			aca5.html
Affordable Care Act Implementation: Nondiscrimination Based on a Health Factor and Wellness Programs	**Q14:** My group health plan gives an annual premium discount of 20 percent of the cost of employee-only coverage to participants who adhere to a wellness program. The wellness program consists of giving an annual cholesterol exam to participants; participants who achieve a cholesterol count of 200 or lower receive the annual premium discount.	**A14:** No. The wellness program is based on a health factor (achieving a cholesterol count of 200 or lower) and is subject to the HIPAA nondiscrimination regulations, including the five criteria described in paragraph (f)(2) of the regulations. In general, among other things, a wellness program subject to the HIPAA nondiscrimination regulations must be available to all similarly situated individuals, provide a reasonable alternative standard, and the reward must be limited to no more than 20 percent of the total cost of coverage. The wellness program described above satisfies the requirement of being available to all similarly situated individuals because the plan provides a reasonable alternative standard and the	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	The plan also provides that if it is unreasonably difficult or medically inadvisable to achieve the targeted cholesterol count within a 60-day period, the plan will make available a reasonable alternative standard that takes the relevant medical condition into account. Does this wellness program violate the HIPAA nondiscrimination regulations?	premium discount is limited to 20 percent of the cost of employee-only coverage.			
Affordable Care Act Implementation: Nondiscrimination Based on a Health Factor and Wellness Programs	**A15:** My group health plan offers two different wellness programs, both of which are offered to all full-time employees enrolled in the plan. The first program requires participants to take a cholesterol test and provides a 20 percent premium discount for every individual with	**A15:** No. In this scenario, the first program is subject to the requirements of the HIPAA nondiscrimination regulations because the premium discount reward is based on an individual satisfying a standard that is related to a health factor (having a cholesterol count under 200). Therefore, the first program must meet the five criteria in the regulations, including the 20 percent limit on the amount of the reward. The second program is not based on an individual satisfying a standard that is related to a health factor, so it does not have to satisfy the five	FAQ Part V	DOL	http://www.dol.gov/ebsa/faqs/faq-aca5.html

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	cholesterol counts under 200. The second program reimburses participants for the cost of a monthly membership to a fitness center. If I participate in both wellness programs and receive both rewards (the 20 percent premium discount and the reimbursement for the cost of a fitness center membership), is my plan violating the HIPAA nondiscrimination regulations?	criteria in the regulations. Furthermore, it is permissible to offer both programs at the same time because the rule limiting the amount of the reward for health-contingent wellness programs to 20 percent of the cost of coverage only applies to programs that require satisfaction of a standard related to a health factor. As previously noted, the Departments intend to propose regulations that use existing regulatory authority under HIPAA to raise the percentage for the maximum reward that can be provided under a health-contingent wellness program to 30 percent before the year 2014 and are also considering what accompanying consumer protections may be needed to prevent the program from being used as a subterfuge for discrimination based on health status. More guidance is expected early next year.			
Affordable Care Act Implementation: Nondiscrimination Based on a Health Factor and Wellness Programs	**Q2:** Will the Departments be issuing regulations addressing PHS Act section 2706(a) prior to its effective date?	**A2:** No. The statutory language of PHS Act section 2706(a) is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2706(a) is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the	FAQ Part XV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca15.html

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		individual market, policy years) beginning on or after January 1, 2014. Until any further guidance is issued, group health plans and health insurance issuers offering group or individual coverage are expected to implement the requirements of PHS Act section 2706(a) using a good faith, reasonable interpretation of the law. For this purpose, to the extent an item or service is a covered benefit under the plan or coverage, and consistent with reasonable medical management techniques specified under the plan with respect to the frequency, method, treatment or setting for an item or service, a plan or issuer shall not discriminate based on a provider's license or certification, to the extent the provider is acting within the scope of the provider's license or certification under applicable state law. This provision does not require plans or issuers to accept all types of providers into a network. This provision also does not govern provider reimbursement rates, which may be subject to quality, performance, or market standards and considerations. The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help			

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		them come into compliance with the provider nondiscrimination provision and will work with families and individuals to help them understand the law and benefit from it as intended. For questions about the provider nondiscrimination provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q1:** On August 22, 2011, the Departments issued proposed regulations and proposed templates in connection with implementation of the Summary of Benefits and	**A1:** The Departments received many comments on the proposed regulations and templates and intend to issue, as soon as possible, final regulations that take into account these comments and other stakeholder feedback. PHS Act section 2715 provides that group health plans and health insurance issuers shall provide the Summary of	FAQ Part VII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca7.html

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	Coverage and Uniform Glossary requirements of PHS Act § 2715. An applicability date "beginning March 23, 2012" was proposed. At the same time, the Departments invited comments generally, as well as on a range of discrete issues, including the timing of the application of the SBC requirement. My plan anticipates that preparation of the summary of benefits and coverage will take several months and require significant resources. In light of the March 23, 2012 proposed applicability date, we are considering moving forward with implementation of the Summary of Benefits and Coverage requirements, using	Benefits and Coverage and Uniform Glossary pursuant to standards developed by the Departments. Accordingly, until final regulations are issued and applicable, plans and issuers are not required to comply with PHS Act section 2715. It is anticipated that the Departments' final regulations, once issued, will include an applicability date that gives group health plans and health insurance issuers sufficient time to comply.			

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	the proposed rules and templates, but are concerned that the final rules and templates will differ from the proposed rules and templates, which would prompt additional implementation costs. What is the timeline for the issuance of future guidance on the summary of benefits and coverage? What actions should my plan be taking now, if any?				
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q1:** When must plans and issuers begin providing the SBC?	**A1:** For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012. For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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		enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012. For disclosures from issuers to group health plans, and with respect to individual market coverage, the SBC must be provided beginning September 23, 2012.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q2:** What is the Departments' basic approach to implementation of the SBC requirement during the first year of applicability?	**A2:** The Departments' basic approach to ACA implementation, as stated in a previous FAQ (see http://www.dol.gov/ebsa/faqs/faq-aca.html), is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law. This approach includes, where appropriate, transition provisions, grace periods, safe harbors, and other policies to ensure that the new provisions take effect smoothly,	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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		minimizing any disruption to existing plans and practices." In addition to the general approach to implementation, in the instructions for completing the SBC, we stated: "To the extent a plan's terms do not reasonably correspond to these instructions, the template should be completed in a manner that is as consistent with the instructions as possible, while still accurately reflecting the plan's terms. This may occur, for example, if a plan provides a different structure for provider network tiers or drug tiers than is represented in the SBC template and these instructions, if a plan provides different benefits based on facility type (such as hospital inpatient versus non-hospital inpatient), in a case where a plan is denoting the effects of a related health flexible spending arrangement or a health reimbursement arrangement, or if a plan provides different cost sharing based on participation in a wellness program." Consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the final regulations. The Departments			

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		intend to work with stakeholders over time to achieve maximum uniformity for consumers and certainty for the regulated community.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q3:** Are plans and issuers required to provide a separate SBC for each coverage tier (e.g., self-only coverage, employee-plus-one coverage, family coverage) within a benefit package?	**A3:** No, plans and issuers may combine information for different coverage tiers in one SBC, provided the appearance is understandable. In such circumstances, the coverage examples should be completed using the cost sharing (e.g., deductible and out-of-pocket limits) for the self-only coverage tier (also sometimes referred to as the individual coverage tier). In addition, the coverage examples should note this assumption.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q4:** If the participant is able to select the levels of deductible, copayments, and co-insurance for a particular benefit package, are plans and issuers required to provide a separate SBC for every possible combination that a participant may select under that benefit package?	**A4:** No, as with the response to Q-3, plans and issuers may combine information for different cost-sharing selections (such as levels of deductibles, copayments, and co-insurance) in one SBC, provided the appearance is understandable. This information can be presented in the form of options, such as deductible options and out-of-pocket maximum options. In these circumstances, the coverage examples should note the assumptions used in creating them. An example of how to note assumptions used in creating coverage examples is provided in the Departments' sample completed SBC.(2)	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation:	**Q5:** If a group health plan is insured and	**A5:** The Departments recognize that different combinations of plans, issuers,	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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Summary of Benefits and Coverage	utilizes "carve-out arrangements" (such as pharmacy benefit managers and managed behavioral health organizations) to help manage certain benefits, who is responsible for providing the SBC with respect to the plan?	and their service providers may have different information necessary to provide an SBC, including the coverage examples. The Departments have determined that, until further guidance is issued, where a group health plan or group health insurance issuer has entered into a binding contractual arrangement under which another party has assumed responsibility (1) to complete the SBC, (2) to provide required information to complete a portion of the SBC, or (3) to deliver an SBC with respect to certain individuals in accordance with the final regulations, the plan or issuer generally will not be subject to any enforcement action by the Departments for failing to provide a timely or complete SBC, provided the following conditions are satisfied: • The plan or issuer monitors performance under the contract, • If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer has the information to correct it, it is corrected as soon as practicable, and • If a plan or issuer has knowledge of a violation of the final regulations and the plan or issuer does not have the information to correct it, the plan or issuer communicates with			

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		participants and beneficiaries regarding the lapse and begins taking significant steps as soon as practicable to avoid future violations.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q6:** If a plan offers participants add-ons to major medical coverage that could affect their cost sharing and other information in the SBC (such as a health flexible spending arrangement (health FSA), health reimbursement arrangement (HRA), health savings account (HSA), or wellness program), is the plan permitted to combine information for all of these add-ons and reflect them in a single SBC?	**A6:** Yes. As stated in the preamble to the final regulations and the instructions for completing the SBC template,(3) plans and issuers are permitted to combine such information in one SBC, provided the appearance is understandable. That is, the effects of such add-ons can be denoted in the appropriate spaces on the SBC for deductibles, copayments, coinsurance, and benefits otherwise not covered by the major medical coverage. In such circumstances, the coverage examples should note the assumptions used in creating them. (The Departments' sample completed SBC(4) provides an example of how to denote the effects of a diabetes wellness program.)	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q7:** The final regulations require the SBC to be provided in certain circumstances within 7 business days. Does that mean the	**A7:** In the context of the final regulations, the term "provided" means sent. Accordingly, the SBC is timely if sent out within 7 business days, even if it is not received until after that period.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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	plan or issuer has 7 business days to send the SBC, or that the SBC must be received within 7 business days?				
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q8:** Are plans and issuers required to provide SBCs to individuals who are COBRA qualified beneficiaries?	**A8:** Yes. While a qualifying event does not, itself, trigger an SBC, during an open enrollment period, any COBRA qualified beneficiary who is receiving COBRA coverage must be given the same rights to elect different coverage as are provided to similarly situated non-COBRA beneficiaries. See 26 CFR 54.4980B-5, Q&A-4(c) (requirement to provide election) and 54.4980B-3, Q&A-3 (definition of similarly situated non-COBRA beneficiary). In this situation, a COBRA qualified beneficiary who has elected coverage has the same rights to receive an SBC as a similarly situated non-COBRA beneficiary. There are also limited situations in which a COBRA qualified beneficiary may need to be offered different coverage at the time of the qualifying event than the coverage he or she was receiving before the qualifying event and this may trigger the right to an SBC. See 26 CFR 54.4980B-5, Q&A-4(b).	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and	**Q9:** What circumstances will trigger the	**A9:** The final regulations require that the SBC be provided in several instances:	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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Coverage	requirement to provide an SBC to a participant or beneficiary in a group health plan? In particular, how do the terms "application" and "renewal" apply to a self-insured plan?	• Upon application. If a plan (including a self-insured group health plan) or an issuer distributes written application materials for enrollment, the SBC must be provided as part of those materials. For this purpose, written application materials include any forms or requests for information, in paper form or through a website or email, that must be completed for enrollment. If the plan or issuer does not distribute written application materials for enrollment (in either paper or electronic form), the SBC must be provided no later than the first date on which the participant is eligible to enroll in coverage. • By first day of coverage (if there are any changes). If there is any change in the information required to be in the SBC that was provided upon application and before the first day of coverage, the plan or issuer must update and provide a current SBC no later than the first day of coverage. • Special enrollees. The SBC must be provided to special enrollees no later than the date on which a summary plan description is required to be provided (90 days from enrollment).			

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		• Upon renewal. If a plan or issuer requires participants and beneficiaries to actively elect to maintain coverage during an open season, or provides them with the opportunity to change coverage options in an open season, the plan or issuer must provide the SBC at the same time it distributes open season materials. If there is no requirement to renew (sometimes referred to as an "evergreen" election), and no opportunity to change coverage options, renewal is considered to be automatic and the SBC must be provided no later than 30 days prior to the first day of the new plan or policy year.(5) • Upon request. The SBC must be provided upon request for an SBC or summary information about the health coverage as soon as practicable but in no event later than seven business days following receipt of the request.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q10:** What are the circumstances in which an SBC may be provided electronically?	**A10:** With respect to group health plan coverage, an SBC may be provided electronically: (1) by an issuer to a plan, and (2) by a plan or issuer to participants and beneficiaries who are eligible but not enrolled for coverage, if: • The format is readily accessible (such as in an html, MS Word, or pdf format);	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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		• The SBC is provided in paper form free of charge upon request; and • If the SBC is provided via an Internet posting (including on the HHS web portal), the issuer timely advises the plan (or the plan or issuer timely advises the participants and beneficiaries) that the SBC is available on the Internet and provides the Internet address. Plans and issuers may make this disclosure (sometimes referred to as the "e-card" or "postcard" requirement) by email. An SBC may also be provided electronically by a plan or issuer to a participant or beneficiary who is covered under a plan in accordance with the Department of Labor's disclosure regulations at 29 CFR 2520.104b-1. Those regulations include a safe harbor for disclosure through electronic media to participants who have the ability to effectively access documents furnished in electronic form at any location where the participant is reasonably expected to perform duties as an employee and with respect to whom access to the employer's or plan sponsor's electronic information system is an integral part of those duties. Under the safe harbor, other individuals may also opt into electronic delivery.			

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		With respect to individual market coverage, a health insurance issuer must provide the SBC, in either paper or electronic form, in a manner that can reasonably be expected to provide actual notice. The SBC may not be provided in electronic form unless: • The format is readily accessible; • If the SBC is provided via an Internet posting, it is placed in a location that is prominent and readily accessible; • The SBC is provided in an electronic form which can be retained and printed; and • The issuer notifies the individual that the SBC is available free of charge in paper form upon request. In addition, a health insurance issuer offering individual market coverage, that provides HealthCare.gov with all the content required to be provided in the SBC, will be deemed compliant with the requirement to provide an SBC upon request prior to application. However, issuers must provide the SBC in paper form upon request for a paper copy, and at all other times as specified in the regulations. In addition, as stated in the regulations, unless the plan or issuer has knowledge of a separate address for a beneficiary, the SBC may be provided to the			

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		participant on behalf of the beneficiary (including by furnishing the SBC to the participant in electronic form).			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q11:** Are issuers who have provided individual market plan information to HealthCare.gov in compliance with PHS Act section 2715 and its implementing regulations already?	**A11:** The deemed compliance provision in the regulation requires issuers in the individual market to provide all of the data elements that are needed to complete the SBC template to HealthCare.gov. If the issuer fails to provide all of the data elements, it would not be deemed to be in compliance with the regulation. Today, HealthCare.gov does not collect all of the elements of an SBC, such as information necessary to complete the coverage examples. However, HHS will collect this information and display it in the format of the SBC template by September 23, 2012, so that providing information to HealthCare.gov fulfills the deemed compliance provision.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q12:** Can the Departments provide model language to meet the requirement to provide an e-card or postcard in connection with evergreen website postings?	**A12:** Yes. Plans and issuers have flexibility with respect to the postcard and may choose to tailor it in many ways. One example is: "Availability of Summary Health Information As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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		Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at: www.website.com/SBC. A paper copy is also available, free of charge, by calling 1-XXX-XXX-XXXX (a toll-free number)."			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q13:** The regulations state that in order to satisfy the requirement to provide the SBC in a culturally and linguistically appropriate manner, a plan or issuer follows the rules in the claims and appeals regulations under PHS Act section 2719. Does this mean that the SBC must include a sentence on the availability of	**A13:** Yes, if the notice is sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. The final SBC regulations provide that a plan or issuer is considered to provide the SBC in a culturally and linguistically appropriate manner if the thresholds and standards of the claims and appeals regulations are met.(6) The claims and appeals regulations outline three requirements that must be satisfied for notices sent to an address in a county in which ten percent or more of the population is literate only in a non-English language. In such cases, the plan or issuer is generally required to provide oral language services in the	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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	language assistance services?	non-English language, provide notices upon request in the non-English language, and include in all English versions of the notices a statement in the non-English language clearly indicating how to access the language services provided by the plan or issuer. Accordingly, plans and issuers must include, in the English versions of SBCs sent to an address in a county in which ten percent or more of the population is literate only in a non-English language, a statement prominently displayed in the applicable non-English language clearly indicating how to access the language services provided by the plan or issuer. In this circumstance, the plan or issuer should include this statement on the page of the SBC with the "Your Rights to Continue Coverage" and "Your Grievance and Appeals Rights" sections. Sample language for this statement is available on the model notice of adverse benefit determination at http://www.dol.gov/ebsa/IABDModelNotice2.doc. Current county-by-county data can be accessed at http://www.cciio.cms.gov/resources/factsheets/clas-data.html. Even in counties where no non-English language meets the ten percent			

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		threshold, a plan or issuer can voluntarily include such a statement in the SBC in any non-English language. Moreover, nothing in the SBC regulations limits an individual's rights to meaningful access protections under other applicable Federal or State law, including Title VI of the Civil Rights Act of 1964.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q14:** Where can plans and issuers find the written translations of the SBC template and the uniform glossary in the non-English languages?	**A14:** Written translations in Spanish, Chinese, Tagalog and Navajo will be available at http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q15:** Is an SBC permitted to simply substitute a cross-reference to the summary plan description (SPD) or other documents for a content element of the SBC?	**A15:** No, an SBC is not permitted to substitute a reference to the SPD or other document for any content element of the SBC. However, an SBC may include a reference to the SPD in the SBC footer. (For example, "Questions: Call 1-800-[insert] or visit us at www.[insert].com for more information, including a copy of your plan's summary plan description.") In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of the SPD in order to supplement or elaborate on that information.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html

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Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q16:** Can a plan or issuer add premium information to the SBC form voluntarily?	**A16:** Yes. If a plan or issuer chooses to add premium information to the SBC, the information should be added at the end of the SBC form.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q17:** Must the header and footer be repeated on every page of the SBC?	**A17:** No. If a plan or issuer chooses, it may include the header only on the first page of the SBC. In addition, a plan or issuer may include the footer only on the first and last page of the SBC, instead of on every page. The OMB control numbers (which were displayed on the SBC template and the Departments' sample completed SBC to inform plans and issuers that the Departments had complied with the Paperwork Reduction Act) should not be displayed on SBCs provided by plans or issuers.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q18:** For group health plan coverage, may the coverage period in the SBC header reflect the coverage period for the group plan as a whole, or must the coverage period be the period applicable to each particular individual enrolled in the plan?	**A18:** The SBC may reflect the coverage period for the group health plan as a whole. Therefore, if a plan is a calendar year plan and an individual enrolls on January 19, the coverage period is permitted to be the calendar year. Plans and issuers are not required to individualize the coverage period for each individual's enrollment.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act	**Q19:** Can issuers and	**A19:** Minor adjustments are permitted	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Summary of Benefits and Coverage	plans make minor adjustments to the SBC format, such as changing row and column sizes? What about changes such as rolling over information from one page to another, which was not permitted by the instructions?	to the row or column size in order to accommodate the plan's information, as long as the information is understandable. The deletion of columns or rows is not permitted. Rolling over information from one page to another is permitted.			aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q20:** Can plan names be generic, such as "Standard Option" or "High Option"?	**A20:** Yes, generic terms may be used.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q21:** Can the issuer's name and the plan name be interchangeable in order?	**A21:** Yes.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q22:** Can barcodes or control numbers be added to the SBC for quality control purposes?	**A22:** Yes, they can be added.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q23:** Is the SBC required to include a statement about whether the plan is a grandfathered health plan?	**A23:** No, although plans may voluntarily choose to add a statement to the end of the SBC about whether the plan is a grandfathered health plan.	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca8.html
Affordable Care Act	**Q24:** My plan is	**A24:** No. The Departments identified in	FAQ Part VIII	DOL	http://www.dol.gov/ebsa/faqs/faq-

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Implementation: Summary of Benefits and Coverage	moving forward to implement the SBC template for the first year of applicability. Are significant changes anticipated for 2014?	the preamble to the final regulations certain discrete changes that would be necessary for plan years (or, in the individual market, policy years) beginning after the first year of applicability. These changes include the addition of a minimum value statement and a minimum essential coverage statement, changes to be consistent with the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits, and the Departments' intent to add additional coverage examples. The Departments are also considering making some refinements consistent with these FAQs and other requests from plans and issuers for clarification and to promote operational efficiencies. No other changes are planned at this time.			aca8.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q1:** A previous FAQ outlined the circumstances in which an SBC may be provided electronically.(1) The FAQ discussed a safe harbor for providing the SBC to participants or beneficiaries covered under the plan who are able to effectively access	**A1:** Yes. The Departments have adopted the following additional safe harbor-. SBCs may be provided electronically to participants and beneficiaries in connection with their online enrollment or online renewal of coverage under the plan. SBCs also may be provided electronically to participants and beneficiaries who request an SBC online. In either case, the individual must have the option to receive a paper copy upon request. (In addition, for individual market issuers that offer online enrollment or renewal,	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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	documents provided in electronic form at the worksite. Are there any additional safe harbors for electronic delivery of SBCs?	the SBC may be provided electronically, at all issuances, to consumers who enroll or renew online, consistent with the regulations.)			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q2:** What are the circumstances that will trigger the requirement for an issuer to provide an SBC to an individual applying for coverage in the individual market, or to a group health plan or its sponsor applying for coverage? In particular, how do the terms "upon application" and "first day of coverage (if there are changes)" apply to an individual (or a plan or its sponsor) shopping for coverage?	**A2:** The regulations state that a health insurance issuer must provide the SBC upon application for health coverage. For this purpose, a plan or issuer must provide the SBC as soon as practicable, but no later than seven business days after receiving a substantially complete application for a health insurance product. If an individual, plan, or plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, an updated SBC is not required to be provided (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q3:** If an individual (or a plan or its sponsor) receives an SBC prior to	**A3:** No. A duplicate SBC is generally not required to be provided at the time of application unless requested by the applicant. However, if by the time the	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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	application for coverage, must an issuer automatically provide another SBC upon application, if the information required to be in the SBC has not changed?	application is filed, there is a change in the information required to be in the SBC, the issuer or plan must update and provide a current SBC to the individual (or plan or its sponsor) as soon as practicable following receipt of the application, but in no event later than seven business days following receipt of the application. Similarly, if an SBC is provided upon application, there is no requirement to provide the SBC again on the first day of coverage, unless there is a change to the information that is required to be in SBC or an SBC is requested by the applicant.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q4:** Are issuers required to provide SBCs to group health plans (or their sponsors) who are "shopping" for coverage, but have not yet submitted an application for coverage?	**A4:** Yes, but only in certain circumstances. The regulations generally provide that an SBC must be provided upon request for an SBC or "summary information about a health insurance product." The latter phrase is intended to ensure that persons who do not ask exactly for a "summary of benefits and coverage" still receive one when they explicitly ask for a summary document with respect to a specific health product. Other, general questions about coverage options or discussions about health products do not trigger the requirement to provide an SBC. (See also, Q1 regarding electronic delivery options for providing SBCs.)	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html
Affordable Care Act Implementation:	**Q5:** A previous FAQ stated that an SBC	**A5:** Yes. While it is not permitted to substitute a reference to any other	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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Summary of Benefits and Coverage	provided in connection with a group health plan may include a reference to the summary plan description (SPD).(2) For SBCs provided in connection with coverage in the individual market, can the SBC refer to other documents associated with the coverage?	document for any content element of the SBC, an SBC may include a reference to another document in the SBC footer. In addition, wherever an SBC provides information that fully satisfies a particular content element of the SBC, it may add to that information a reference to specified pages or portions of other documents in order to supplement or elaborate on that information.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q6:** Are certain electronic features (such as scrolling and expansion of columns) permitted when displaying the SBC electronically?	**A6:** Yes. Minor adjustments are permitted to accommodate the plan's or issuer's information and electronic display method, such as expansion of columns. Additionally, it is permissible to display the SBC electronically on a single webpage, so the viewer can scroll through the information required to be in the SBC without having to advance through pages (as long as a printed version is available that meets the formatting requirements of the SBC). However, the deletion of columns or rows is not permitted when displaying a complete SBC. (For more on minor adjustments, see FAQs Part VIII at www.dol.gov/ebsa/faqs/faq-aca8.html and	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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		cciio.cms.gov/resources/factsheets/aca_implementation_faqs8.html. Specifically, Q3 and Q4 state that "plans and issuers may combine information …provided the appearance is understandable" and Q19 states that "minor adjustments are permitted…as long as the information is understandable.")			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q7:** Some plans or issuers provide web-based or print materials to illustrate the differences between benefit package options (including comparison charts and broker comparison websites). Is it permissible to "combine" SBCs or SBC elements to provide a side-by-side comparison?	**A7:** Yes. Issuers and plans (and agents and brokers working with such plans) may display SBCs, or parts of SBCs, in a way that facilitates comparisons of different benefit package options by individuals and employers shopping for coverage. For example, on a website, viewers could be allowed to select a comparison of only the deductibles, out-of-pocket limits, or other cost sharing of several benefit package options. This could be achieved by providing the "deductible row" of the SBC for several benefit packages, but without having to repeat the first one or two columns, as appropriate, of the SBC for each of the benefit packages. However, such a chart, website, or other comparison does not, itself, satisfy the requirements under PHS Act section 2715 and the final regulations to provide the SBC. The full SBC for all the benefit packages included in the comparison view/tool must be made available in accordance with the regulations and other guidance.	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q8:** Under what circumstances can penalties be imposed for failure to provide the SBC or the uniform glossary?	**A8:** PHS Act section 2715(f) states that an entity is subject to a fine if the entity "willfully fails to provide the information required under this section." As stated in previous FAQs,(3) the Departments' basic approach to ACA implementation is: "[to work] together with employers, issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is and will continue to be marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law." Accordingly, consistent with this guidance, during this first year of applicability, the Departments will not impose penalties on plans and issuers that are working diligently and in good faith to comply.	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q9:** For the first year of applicability,(4) can the Departments provide further assistance with regard to the	**A9:** Yes. The Departments are developing a calculator that plans and issuers can use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion; because this approach will be	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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	coverage examples, such as a streamlined calculator?	less accurate, it will be allowed as a transitional tool for the first year of applicability.(5) The calculator will allow plans and issuers to input a discrete number of elements about the benefit package. Calculator inputs generally are expected to be taken from data fields used to populate the front portion of the SBC template. (See cciio.cms.gov/resources/other/index.html#sbcug for a list of calculator inputs.) The output will be a coverage example that can be added to the corresponding SBC. The Departments will also provide the algorithm that was used to create the calculator. The calculator and algorithm will be posted at cciio.cms.gov/resources/other/index.html#sbcug soon.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q10:** A previous FAQ discussed the utilization of "carve-out arrangements" under which a plan or issuer contracts with a service provider to help manage certain benefits under the plan or policy.(6) In another type of "carve-out arrangement," a plan sponsor may purchase an	**A10:** What are an issuer's obligations to provide an SBC with respect to benefits it does not insure? Unless it contracts otherwise, an issuer has no obligation to provide coverage information for benefits that it does not insure. However, group health plan administrators are responsible for providing complete SBCs with respect to a plan. A plan administrator that uses two or more insurance products provided by separate issuers with respect to a single group health plan may synthesize the information into a single SBC, or may contract with one of	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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	insurance product for certain coverage from a particular issuer and purchase a separate insurance product or self-insure with respect to other coverage (such as outpatient prescription drug coverage). In these circumstances, the first issuer may or may not even know of the existence of other coverage, or whether the plan sponsor has arranged the two benefit packages as a single plan or two separate plans.	its issuers (or other service providers) to perform that function. Due to the administrative challenges of combining benefit package information from multiple issuers, during the first year of applicability, for enforcement purposes, with respect to a group health plan that uses two or more issuers, the Departments will consider the provision of multiple partial SBCs that, together, provide all the relevant information to meet the SBC content requirements. In such circumstances, the plan administrator should take steps (such as a cover letter or a notation on the SBCs themselves) to indicate that the plan provides coverage using multiple different insurers and that individuals who would like assistance understanding how these products work together may contact the plan administrator for more information (and provide the contact information).(7)			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q11:** A previous FAQ provided a link where written translations for the SBC template and the uniform glossary would be available in the future.(8) Are these translations available?	**A11:** Written translations in Spanish, Chinese, and Tagalog are now available. Navajo translations will be available shortly. For more information, see CCIIO website at cciio.cms.gov/programs/consumer/summaryandglossary/index.html.	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q12:** Are health insurance issuers required to provide SBCs for insurance products that are no longer being offered for purchase?	**A12:** The Departments understand that most plans and issuers have to develop new databases and technology systems in order to extract information about coverage terms and provide SBCs. The Departments also understand that, with respect to insurance products that are no longer being offered for purchase (sometimes referred to as closed blocks of business), there is a significant volume of data that is not stored in electronic form or is not stored in an information system that that is compatible with the new electronic systems being developed for the SBC. Accordingly, due to the additional administrative complexities with respect to providing SBCs with respect to closed blocks of business, the Departments will not take any enforcement action against a plan or issuer for failing to provide an SBC before September 23, 2013 with respect to an insured product that is no longer being actively marketed for business, provided the SBC is provided no later than September 23, 2013 (at which time, enrollees and small employers will have new opportunities to compare coverage options available through an Exchange).	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q13:** Expatriate plans and policies face special circumstances and considerations in	**A13:** Yes. The Departments recognize that expatriate coverage carries additional administrative costs and barriers in filling out SBCs, including benefit and claims systems that are	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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	complying with the SBC requirements. Can the Departments provide any assistance or relief with respect to expatriate coverage?	distinct from those for domestic coverage, which makes compliance more difficult. Therefore, for purposes of enforcement, the Departments will not take any enforcement action against a group health plan or group health insurance issuer for failing to provide an SBC with respect to expatriate coverage during the first year of applicability.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q14:** Other than the FAQs, are there any updates to the SBC template and related documents on the Departments' websites that I need to know about?	**A14:** Yes. In the diabetes treatment scenario, the version originally posted contained a typographical error, listing the allowed amount for insulin as $11.92, rather than $119.20 – a difference that impacts the total cost of care for diabetes in the coverage example calculations. To correct this error, the Departments have posted updated versions of the SBC template, the sample completed SBC, and the guide for coverage examples calculations – diabetes scenario. The updated SBC template and sample completed SBC also include sample taglines for obtaining translated documents, to be included if appropriate consistent with paragraph (a)(5) of the regulations, as well as updated Sample Care Costs amounts for the diabetes coverage example, due to more accurate rounding in making these calculations. Finally, the updated versions include some appearance modifications (such as changes in bolding, underlining,	FAQ Part IX	DOL	http://www.dol.gov/ebsa/faqs/faq-aca9.html

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		shading, capitalization, margin justification, use of hyphens, and row and column sizing) to ensure the document is accessible to individuals with disabilities, consistent with section 508 of the Rehabilitation Act. Plans and issuers may use either version, or may make similar modifications to their own SBCs, without violating the appearance requirements for an SBC. The updated versions of these documents are labeled "corrected on May 11, 2012" in the lower right corner of the first page and are available at www.dol.gov/ebsa/healthreform and cciio.cms.gov. These three documents replace the prior versions issued contemporaneously with the final regulations in February 2012.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q1:** I am an employer sponsoring a group health plan. One of the benefit packages is a Medicare Advantage plan. Am I required to provide an SBC for the Medicare Advantage package?	**A1:** No. Medicare Advantage benefits are Medicare benefits (financed by the Medicare Trust fund and equivalent to Medicare A and B benefits, which are set by Congress and regulated by the Centers for Medicare & Medicaid Services (CMS)). They are, therefore, not health insurance coverage and Medicare Advantage organizations are not required to provide an SBC with respect to such benefits. Pending further guidance, the Departments will not take any enforcement action against a group health plan because it does not provide	FAQ Part X	DOL	http://www.dol.gov/ebsa/faqs/faq-aca10.html

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		an SBC with respect to a Medicare Advantage benefit package.(1) This enforcement policy does not affect other disclosure requirements administered by CMS that apply to Medicare Advantage organizations. These separately required disclosures will ensure that enrollees in these plans receive the necessary information about their coverage and benefits. Nor does this policy affect the obligation of group health plans that offer Medicare Advantage benefit options to ensure that SBCs are provided with respect to other benefit packages that they offer.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q1:** What templates should plans and issuers use for the SBCs and the uniform glossary required to be provided after the first year of applicability?	**A1:** An updated SBC template (and sample completed SBC) are now available at cciio.cms.gov and www.dol.gov/ebsa/healthreform. These documents are authorized for use with respect to group health plans and group and individual health insurance coverage for SBCs provided with respect to coverage beginning on or after January 1, 2014, and before January 1, 2015 (referred to in this guidance document as "the second year of applicability"). The only change to the SBC template and sample completed SBC is the addition of statements of whether the plan or coverage provides MEC (as defined under section 5000A(f) of the	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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		Internal Revenue Code 1986) and whether the plan or coverage meets the MV requirements (that is, the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage is not less than 60 percent of such costs). On page 4 of the SBC template (and illustrated on page 6 of the sample completed SBC), a plan or issuer should indicate in the designated entry on the SBC template that the plan or coverage "does" or "does not" provide MEC and whether the plan or coverage "does" or "does not" meet applicable MV requirements. There are no changes to the uniform glossary. There are also no changes to the Instructions for Completing the SBC (for either group or individual health coverage), "Why This Matters" language for the SBC, or to the coverage examples.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q2:** Our plan is already working on the process of preparing SBCs for issuance in the second year of applicability and it would be an administrative burden to add the new data element to	**A2:** Yes. To the extent a plan or issuer is unable to modify the SBC template for disclosures required to be provided with respect to the second year of applicability, the Departments will not take any enforcement action against a plan or issuer for using the template authorized for the first year of applicability, provided that the SBC is furnished with a cover letter or similar disclosure stating whether the plan or	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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	the template at this point in the process. Is any relief available to provide information about MEC and MV without changing the SBC template?	coverage does or does not provide MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided under the plan or coverage does or does not meet the MV requirement under the Affordable Care Act. The language for these statements is as follows: Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy [does/does not] provide minimum essential coverage. Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q3:** A previous FAQ stated that the Departments intended to make changes to the SBC template for 2014 to be consistent with	**A3:** No. As stated earlier, the only change to the SBC template and sample completed SBC is the addition of information to indicate whether the plan or coverage provides MEC and whether the plan's or coverage's share of the total allowed costs of benefits provided	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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	the Affordable Care Act's requirement to eliminate all annual limits on essential health benefits.(4) Have the Departments made any changes related to this requirement?	under the plan or coverage meets applicable MV requirements under the Affordable Care Act. Plans and issuers should continue to complete the SBC template consistent with the Instructions for Completing the SBC (for either group or individual health coverage, as applicable) for the Important Questions chart that appears on page 1 of the SBC: In the Answers column, the plan or issuer should respond "No," where the template asks, "Is there an overall annual limit on what the plan pays?", as plans and issuers are generally prohibited from imposing annual limits on the dollar value of essential health benefits for plan years (in the individual market, policy years) beginning on or after January 1, 2014.(5) In the Why This Matters column, the plan or issuer must show the following language: "The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits."(6) Additionally, as applicable, plans and issuers should continue to include information regarding annual or lifetime dollar limits on specific covered benefits as required in the chart starting on page 2 of the SBC (in the Limitations & Exceptions column), as described in the			

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		Instructions for Completing the SBC (for either group or individual health coverage, as applicable). To the extent a plan or issuer wishes to modify the SBC template for disclosures required to be provided for the second year of applicability to remove this information, the Departments will not take any enforcement action against a plan or issuer for removing the entire row in the Important Questions chart on page 1 of the SBC (with the question: "Is there an overall annual limit on what the plan pays?").			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q4:** A previous FAQ stated that the Departments intended to add additional coverage examples for 2014.(7) Have the Departments made any changes related to this requirement?	**A4:** To help transition to new market changes in 2014, the Departments believe it is prudent to maintain the current coverage examples. Additional coverage examples are not required as part of the SBC at this time. As with the SBC authorized for the first year of applicability, the documents authorized for the second year of applicability continue to require the same two coverage examples authorized for the first year of applicability – having a baby (normal delivery) and managing type 2 diabetes (routine maintenance of a well-controlled condition).	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q5:** Safe harbors and other enforcement relief were provided by the Departments	**A5:** Yes. As stated in previous FAQs,(8) the Departments' basic approach to ACA implementation is: "[to work] together with employers,	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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	related to the requirement to provide an SBC and a uniform glossary for the first year of applicability. Will this relief be extended?	issuers, States, providers and other stakeholders to help them come into compliance with the new law and [to work] with families and individuals to help them understand the new law and benefit from it, as intended. Compliance assistance is a high priority for the Departments. Our approach to implementation is, and will continue to be, marked by an emphasis on assisting (rather than imposing penalties on) plans, issuers and others that are working diligently and in good faith to understand and come into compliance with the new law." In recognition of and to ensure a smooth transition to new market changes in 2014, the Departments believe it is prudent to extend the following enforcement relief to apply through the end the second year of applicability: Affordable Care Act Implementation FAQs Part VIII, Q2 (regarding the Departments' basic approach to implementation of the SBC requirements during the first year of applicability);(9) Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);(10) Affordable Care Act Implementation FAQs Part IX, Q8 (regarding penalties for failure to provide the SBC or			

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		uniform glossary);(11) Affordable Care Act Implementation FAQs Part IX, Q9 (regarding the coverage examples calculator);(12) and related information related to use of the coverage examples calculator;(13) Affordable Care Act Implementation FAQs Part IX, Q10 (regarding an issuer's obligation to provide an SBC with respect to benefits it does not insure);(14) and Affordable Care Act Implementation FAQs Part IX, Q13 (regarding expatriate coverage);(15) In addition, the following enforcement relief continues to apply through the second year of applicability, consistent with existing guidance: The Special Rule contained in the Instruction Guides for Group and Individual Coverage;(16) Affordable Care Act Implementation FAQs Part IX, Q1 (regarding the circumstances in which an SBC may be provided electronically);(17) and Affordable Care Act Implementation FAQs Part X, Q1 (regarding Medicare Advantage).(18) Additionally, Affordable Care Act Implementation FAQs Part VIII, Q5 (regarding use of carve-out arrangements) applies "until further guidance is issued." The relief provided in this Affordable Care Act			

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		Implementation FAQs Part VIII, Q5 continues to apply, and plans and issuers may rely on this relief at least through the end of 2014. This guidance supersedes any previous subregulatory guidance (including FAQs) stating that enforcement relief for the SBC and uniform glossary requirements is limited to the first year of applicability.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q6:** A previous FAQ provided an enforcement safe harbor until September 23, 2013 for plans and issuers with respect to insurance products that are no longer being offered for purchase ("closed blocks of business").(19) Will this relief be extended?	**A6:** Yes. The relief provided in this FAQ extends this date to September 23, 2014 for plans and issuers with respect to an insured product that meets three conditions: The insured product is no longer being actively marketed; The health insurance issuer stopped actively marketing the product prior to September 23, 2012, when the requirement to provide an SBC was first applicable to health insurance issuers; and The health insurance issuer has never provided an SBC with respect to the insured product. That is, if a health insurance product is not being actively marketed and the health insurance issuer has not actively marketed the product at any time on or after September 23, 2012, the Departments will not take any enforcement action against the plan or	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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		issuer for failing to provide an SBC before September 23, 2014 with respect to a product, provided the SBC is provided for that product no later than September 23, 2014. However, if an insured product was actively marketed for business on or after September 23, 2012, and is no longer being actively marketed for business, or if the plan or issuer ever provided an SBC in connection with the insured product, the plan and issuer must provide the SBC with respect to such coverage, as required by PHS Act section 2715 and the final regulations.			
Affordable Care Act Implementation: Summary of Benefits and Coverage	**Q7:** The final regulations regarding the SBC included an anti-duplication provision for group health coverage clarifying that an entity required to provide an SBC would be considered to have satisfied that requirement with respect to an individual if another party provides a timely and complete SBC.(20) Is a similar anti-duplication rule applicable for student	**A7:** Yes. On March 21, 2012, HHS issued a final rule establishing requirements for student health insurance coverage.(21) The final rule defines student health insurance coverage as a type of individual health insurance coverage provided pursuant to a written agreement between an institution of higher education and a health insurance issuer.(22) HHS is extending the anti-duplication rule for group health coverage set forth in the final SBC regulations to student health insurance coverage, as defined in in 45 CFR 147.145(a). Therefore, the requirement to provide an SBC with respect to an individual will be considered satisfied for an entity (such as an institution of higher education) if	FAQ Part XIV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca14.html

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	health insurance coverage?	another party (such as a health insurance issuer) provides a timely and complete SBC to the individual.			
Affordable Care Act Implementation: Notice of Coverage Options Available Through the Exchanges	**Q1:** When do employers have to comply with the new notice requirements in section 18B of the FLSA?	**A1:** Section 18B of the FLSA provides that employer compliance with the notice requirements of that section must be carried out "[i]n accordance with regulations promulgated by the Secretary [of Labor]." Accordingly, it is the view of the Department of Labor that, until such regulations are issued and become applicable, employers are not required to comply with FLSA section 18B. The Department of Labor has concluded that the notice requirement under FLSA section 18B will not take effect on March 1, 2013 for several reasons. First, this notice should be coordinated with HHS's educational efforts and Internal Revenue Service (IRS) guidance on minimum value. Second, we are committed to a smooth implementation process including providing employers with sufficient time to comply and selecting an applicability date that ensures that employees receive the information at a meaningful time. The Department of Labor expects that the timing for distribution of notices will be the late summer or fall of 2013, which will coordinate with the open enrollment period for Exchanges.	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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		The Department of Labor is considering providing model, generic language that could be used to satisfy the notice requirement. As a compliance alternative, the Department of Labor is also considering allowing employers to satisfy the notice requirement by providing employees with information using the employer coverage template as discussed in the preamble to the Proposed Rule on Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing (78 FR 4594, at 4641), which will be available for download at the Exchange web site as part of the streamlined application that will be used by the Exchange, Medicaid, and CHIP. Future guidance on complying with the notice requirement under FLSA section 18B is expected to provide flexibility and adequate time to comply.			
Affordable Care Act Implementation: Compliance of Health Reimbursement Arrangements with Public Health Service Act section	**Q2:** May an HRA used to purchase coverage on the individual market be considered integrated with that individual	**A2:** No. The Departments intend to issue guidance providing that for purposes of PHS Act section 2711, an employer-sponsored HRA cannot be integrated with individual market coverage or with an employer plan that	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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2711	market coverage and therefore satisfy the requirements of PHS Act section 2711?	provides coverage through individual policies and therefore will violate PHS Act section 2711.			
Affordable Care Act Implementation: Compliance of Health Reimbursement Arrangements with Public Health Service Act section 2711	**Q3:** If an employee is offered coverage that satisfies PHS Act section 2711 but does not enroll in that coverage, may an HRA provided to that employee be considered integrated with the coverage and therefore satisfy the requirements of PHS Act section 2711?	**A3:** No. The Departments intend to issue guidance under PHS Act section 2711 providing that an employer-sponsored HRA may be treated as integrated with other coverage only if the employee receiving the HRA is actually enrolled in that coverage. Any HRA that credits additional amounts to an individual when the individual is not enrolled in primary coverage meeting the requirements of PHS Act section 2711 provided by the employer will fail to comply with PHS Act section 2711.	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html
Affordable Care Act Implementation: Compliance of Health Reimbursement Arrangements with Public Health Service Act section 2711	**Q4:** How will amounts that are credited or made available under HRAs under terms that were in effect prior to January 1, 2014, be treated?	**A4:** The Departments anticipate that future guidance will provide that, whether or not an HRA is integrated with other group health plan coverage, unused amounts credited before January 1, 2014, consisting of amounts credited before January 1, 2013 and amounts that are credited in 2013 under the terms of an HRA as in effect on January 1, 2013 may be used after December 31, 2013 to reimburse medical expenses in accordance with those terms without causing the HRA to fail to comply with PHS Act section 2711. If the HRA terms in effect on January 1, 2013, did not prescribe a set amount or amounts to	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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		be credited during 2013 or the timing for crediting such amounts, then the amounts credited may not exceed those credited for 2012 and may not be credited at a faster rate than the rate that applied during 2012			
Affordable Care Act Implementation: Disclosure of Information Related to Firearms	**Q5:** Does PHS Act section 2717(c) restrict communications between health care professionals and their patients concerning firearms or ammunition?	**A5:** No. While we have yet to issue guidance on this provision, the statute prohibits an organization operating a wellness or health promotion program from requiring the disclosure of information relating to certain information concerning firearms. However, nothing in this section prohibits or otherwise limits communication between health care professionals and their patients, including communications about firearms. Health care providers can play an important role in promoting gun safety.	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html
Affordable Care Act Implementation: Self-Insured Employer Prescription Drug Coverage Supplementing Medicare Part D Coverage Provided through Employer Group Waiver Plans	**Q6:** Must self-insured prescription drug coverage that supplements the standard Medicare Part D coverage through EGWPs comply with the health coverage requirements?	**A6:** Pending further guidance, the Departments will not take any enforcement action against a group health plan that is an EGWP because the non-Medicare supplemental drug benefit does not comply with the health coverage requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code. This enforcement policy does not affect other requirements administered by the Centers for Medicare & Medicaid Services that apply to providers of such	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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		coverage. The Centers for Medicare & Medicaid Services intends to issue related guidance concerning insured coverage that provides non-Medicare supplemental drug benefits shortly.			
Affordable Care Act Implementation: Fixed Indemnity Insurance	**Q7:** What are the circumstances under which fixed indemnity coverage constitutes excepted benefits?	**A7:** The Departments' regulations provide that a hospital indemnity or other fixed indemnity insurance policy under a group health plan provides excepted benefits only if: • The benefits are provided under a separate policy, certificate, or contract of insurance; • There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and • The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. The regulations further provide that to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. Various situations have come to the	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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		attention of the Departments where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at $15 per prescription. In such circumstances, for doctors' visits, surgery, and prescription drugs, payment is made not on a per-period basis, but instead is based on the type of procedure or item, such as the surgery or doctor visit actually performed or the prescribed drug, and the amount of payment varies widely based on the type of surgery or the cost of the drug. Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period)," a policy such as this is not hospital indemnity or other fixed indemnity insurance, and is therefore not excepted benefits. When a policy pays on a per-service basis as opposed to on a per-period basis, it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits. The Departments plan to work with the States to ensure that health insurance issuers comply with the relevant requirements for different types of insurance policies and provide			

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		consumers with the protections of the Affordable Care Act.			
Affordable Care Act Implementation: Payment of PCORI Fees	**Q8:** Does Title I of ERISA prohibit a multiemployer plan's joint board of trustees from paying the Code section 4376 fee from assets of the plan?	**A8:** In the case of a multiemployer plan defined in ERISA section 3(37), the plan sponsor liable for the fee would generally be the independent joint board of trustees appointed by the participating employers and employee organization, and directed pursuant to a collective bargaining agreement to establish the employee benefit plan. Normally, such a joint board of trustees has no function other than to sponsor and administer the multiemployer plan, and it has no source of funding independent of plan assets to satisfy the Code section 4376 statutory obligation. The fee involved is not an excise tax or similar penalty imposed on the trustees in connection with a violation of federal law or a breach of their fiduciary obligations in connection with the plan. Nor would the joint board be acting in a capacity other than as a fiduciary of the plan in paying the fee.(4) In such circumstances, it would be unreasonable to construe the fiduciary provisions of ERISA as prohibiting the use of plan assets to pay such a fee to the Federal government. Thus, unless the plan document specifies a source other than plan assets for payment of the fee under Code section 4376, such a payment from plan assets would be permissible under ERISA.	FAQ Part XI	DOL	http://www.dol.gov/ebsa/faqs/faq-aca11.html

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		There may be rare circumstances where sponsors of employee benefit plans that are not multiemployer plans would also be able to use plan assets to pay the Code section 4376 fee, such as a VEBA that provides retiree-only health benefits where the sponsor is a trustee or board of trustees that exists solely for the purpose of sponsoring and administering the plan and that has no source of funding independent of plan assets. The same conclusion would not necessarily apply, however, to other plan sponsors required to pay the fee under Code section 4376. For example, a group or association of employers that act as a plan sponsor but that also exist for reasons other than solely to sponsor and administer a plan may not use plan assets to pay the fee even if the plan uses a VEBA trust to pay benefits under the plan. The Department of Labor would expect that such an entity or association, like employers that sponsor single employer plans, would have to identify and use some other source of funding to pay the Code section 4376 fee.			
Affordable Care Act Implementation: Limitations on Cost Sharing under the ACA	**Q1:** Who must comply with the deductible limitations under	**A1:** The HHS final regulation on standards related to essential health benefits implements the deductible provisions described in section	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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	PHS Act section 2707(b)?	1302(c)(2) for non-grandfathered[1] health insurance coverage and qualified health plans offered in the small group market, including a provision implementing section 1302(c)(2)(C) so that such small group market health insurance coverage may exceed the annual deductible limit if it cannot reasonably reach a given level of coverage (metal tier) without exceeding the deductible limit.[2] With respect to self-insured and large group health plans, as explained in the preamble to the HHS final regulations, the Departments intend to engage in future rulemaking to implement PHS Act section 2707(b). The Departments continue to believe that only plans and issuers in the small group market are required to comply with the deductible limit described in section 1302(c)(2). Public input is welcome in advance of a future rulemaking, which will implement that only plans and issuers in the small group market will be subject to the deductible limit. Please send comments by April 22, 2013 to e.ohpsca-2707.ebsa@dol.gov. Until that rulemaking is promulgated and effective, the Departments have determined that a self-insured or large group health plan can rely on the Departments' stated intention to apply			

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		the deductible limits imposed by section 1302(c)(2) of the Affordable Care Act only on plans and issuers in the small group market.			
Affordable Care Act Implementation: Limitations on Cost Sharing under the ACA	**Q2:** Who must comply with the annual limitation on out-of-pocket maximums under PHS Act section 2707(b)?	**A2:** As stated in the preamble to the HHS final regulation on standards related to essential health benefits, the Departments read PHS Act section 2707(b) as requiring all non-grandfathered group health plans to comply with the annual limitation on out-of-pocket maximums described in section 1302(c)(1) of the Affordable Care Act.[3] The Departments recognize that plans may utilize multiple service providers to help administer benefits (such as one third-party administrator for major medical coverage, a separate pharmacy benefit manager, and a separate managed behavioral health organization). Separate plan service providers may impose different levels of out-of-pocket limitations and may utilize different methods for crediting participants' expenses against any out-of-pocket maximums. These processes will need to be coordinated under section 1302(c)(1), which may require new regular communications between service providers. The Departments have determined that, only for the first plan year beginning on	FAQ Part XII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca12.html

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		or after January 1, 2014, where a group health plan or group health insurance issuer utilizes more than one service provider to administer benefits that are subject to the annual limitation on out-of-pocket maximums under section 2707(a) or 2707(b), the Departments will consider the annual limitation on out-of-pocket maximums to be satisfied if both of the following conditions are satisfied: a.The plan complies with the requirements with respect to its major medical coverage (excluding, for example, prescription drug coverage and pediatric dental coverage); and b.To the extent the plan or any health insurance coverage includes an out-of-pocket maximum on coverage that does not consist solely of major medical coverage (for example, if a separate out-of-pocket maximum applies with respect to prescription drug coverage), such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1). The Departments note, however, that existing regulations implementing Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[4] prohibit a group health plan (or health insurance coverage offered in connection with a group health plan) from applying a cumulative financial			

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		requirement or treatment limitation, such as an out-of-pocket maximum, to mental health or substance use disorder benefits that accumulates separately from any such cumulative financial requirement or treatment limitation established for medical/surgical benefits. Accordingly, under MHPAEA, plans and issuers are prohibited from imposing an annual out-of-pocket maximum on all medical/surgical benefits and a separate annual out-of-pocket maximum on all mental health and substance use disorder benefits.			
Affordable Care Act Implementation: Expatriate Health Plans	**Q1:** To what extent is expatriate group health insurance coverage subject to the provisions of the Affordable Care Act?	**A1:** The Departments recognize that expatriate health plans may face special challenges in complying with certain provisions of the Affordable Care Act. In particular, challenges in reconciling and coordinating the multiple regulatory regimes that apply to expatriate health plans might make it impossible or impracticable to comply with all the relevant rules at least in the near term. For example, independent review organizations may not exist abroad, and it may be difficult for certain preventive services to be provided, or even be identified as preventive, when such services are provided outside the United States by clinical providers that use different code sets and medical terminology to identify services. Further, expatriate issuers may face challenges and delays in communicating	FAQ Part XIII	DOL	http://www.dol.gov/ebsa/faqs/faq-aca13.html

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		with enrollees living abroad, and, due to the complex nature of these plans, standardized benefits disclosures can be difficult for issuers to produce. Expatriate health plans may require additional regulatory approvals from foreign governments, and, in some circumstances, it is possible that domestic and foreign law requirements conflict. While the Departments gather further information and analyze these challenges to determine what actions may be appropriate regarding the current requirements under the Affordable Care Act, the Departments have determined that, for plans with plan years ending on or before December 31, 2015, with respect to expatriate health plans, the Departments will consider the requirements of subtitles A and C of Title I of the Affordable Care Act satisfied if the plan and issuer comply with the pre-Affordable Care Act version of Title XXVII of the Public Health Service Act. References to subtitles A and C of Title I of the Affordable Care Act also include the corresponding provisions imported into section 715 of the Employee Retirement Income Security Act (ERISA) and section 9815 of the Internal Revenue Code.			

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		For purposes of this temporary transitional relief, an expatriate health plan is an insured group health plan with respect to which enrollment is limited to primary insureds who reside outside of their home country for at least six months of the plan year and any covered dependents, and its associated group health insurance coverage. This definition is also the definition of "expatriate health coverage" under 45 CFR 153.400(a)(1)(iii) during this temporary transitional period (that is, for plans with plan years ending on or before December 31, 2015). Expatriate health plans must, as a condition of this transitional relief, comply with the pre-Affordable Care Act version of Title XXVII of the PHS Act and other applicable law under ERISA and the Internal Revenue Code, including, for example, the mental health parity provisions, the HIPAA nondiscrimination provisions, the ERISA section 503 requirements for claims procedures, and any reporting and disclosure obligations under ERISA Part 1. The Departments note that coverage provided under an expatriate group health plan is a form of minimum			

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		essential coverage under section 5000A of the Internal Revenue Code. The Departments request comments on and information about the unique challenges that expatriate health plans may face in complying with provisions of the Affordable Care Act, including information about which particular types of plans face these challenges and with respect to which particular provisions of the Affordable Care Act. Please send comments by May 8, 2013 to e.ohpsca-expat.ebsa@dol.gov.			
Affordable Care Act Implementation: Annual Limit Waiver Expiration Date based on a Change to a Plan or Policy Year	**Q1:** If a group health plan or health insurance issuer that was granted a waiver from the annual limits requirements under Public Health Service Act (PHS Act) section 2711 changes its plan year (or, in the individual market, policy year) prior to the waiver expiration date, can that change modify the expiration date of the waiver?	**A1:** No. Changing the plan year (or, in the individual market, policy year) does not change the waiver expiration date. Annual limit waivers under PHS Act section 2711(1) were approved by HHS for the plan or policy year in effect when the plan or issuer applied for the waiver. The same holds true for waiver extensions. They extended the waiver based on the date of the plan or policy year in effect when the initial application was submitted. As a result, waiver recipients that change their plan or policy years will not extend the expiration date of their waivers. For example, if a waiver approval letter states that a waiver is granted for an April 1, 2013 plan or policy year, the waiver will expire on March 31, 2014, regardless of whether the plan or issuer	FAQ Part XV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca15.html

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		later amends its plan or policy year. That said, waiver recipients may terminate the waiver at any time prior to its approved expiration date, for example, on December 31, 2013 rather than on March 31, 2014. Additionally, HHS requested that each plan or issuer provide its effective dates of coverage as part of its annual limit waiver application, in part so that HHS would have a record of the waiver's expiration date. As noted in the Technical Instructions,(2) waiver recipients must retain all records pertaining to their waiver applications to permit HHS to conduct audits of waiver applications. If there is a discrepancy between the plan or policy year in an original application and a subsequent annual update, HHS may review the waiver to determine whether the group health plan or health insurance issuer is in compliance with HHS's policy on annual limit waivers.			
Affordable Care Act Implementation: Coverage for Individuals Participating in Approved Clinical Trials	**Q3:** Will the Departments be issuing regulations addressing PHS Act section 2709 prior to its effective date?	**A3:** No. The statutory language of PHS Act section 2709 is self-implementing and the Departments do not expect to issue regulations in the near future. PHS Act section 2709 is applicable to non-grandfathered group health plans and health insurance issuers offering group or individual health insurance coverage for plan years (in the individual market, policy years) beginning on or after	FAQ Part XV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca15.html

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		January 1, 2014. Until any further guidance is issued, group health plans and health insurance issuers are expected to implement the requirements of PHS Act section 2709 using a good faith, reasonable interpretation of the law. The Departments will work together with employers, plans, issuers, states, providers, and other stakeholders to help them come into compliance with the law and will work with families and individuals to help them understand the coverage for clinical trials provision and benefit from it as intended. For questions about the coverage for clinical trials provision, including complaints regarding compliance with the statutory provision by health insurance issuers, contact your state department of insurance (contact information is available by visiting www.healthcare.gov/using-insurance/managing/consumer-help/index.html) or the Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight at 1-888-393-2789. For employment-based group health plan coverage, you also may contact the Department of Labor at www.askebsa.dol.gov or 1-866-444-3272.			

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Affordable Care Act Implementation:	**Q4:** When do plans and issuers have to comply with the transparency in coverage reporting requirements under section 1311(e)(3) of the Affordable Care Act and section 2715A of the PHS Act?	**A4:** Section 1311(e)(3) of the Affordable Care Act, as implemented at 45 CFR 155.1040(a) and 156.220, requires QHP issuers to submit specified information to the Marketplace and other entities in a timely and accurate manner. However, because QHP issuers will not have some of the data necessary for reporting under this requirement until during or after the first year of operation of their QHPs (e.g., QHP enrollment and disenrollment), HHS is clarifying that, in order to comply with section 1311(e)(3) as implemented at 45 CFR 155.1040(a) and 156.220, QHP issuers will begin submitting information only after QHPs have been certified as QHPs for one benefit year.(8) Similarly, because section 2715A of the PHS Act simply extends the transparency provisions set forth in section 1311(e)(3) of the Affordable Care Act to group health plans and health insurance issuers offering group and individual health insurance coverage, the Departments clarify that the reporting requirements under section 2715A of the PHS Act will become applicable to group health plans and health insurance issuers offering group and individual health insurance coverage no sooner than when the reporting requirements under section	FAQ Part XV	DOL	http://www.dol.gov/ebsa/faqs/faq-aca15.html

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		1311(e)(3) of the Affordable Care Act become applicable. As previously stated, the Departments will coordinate regulatory guidance on the transparency in coverage standards for coverage offered inside and outside of the Marketplaces.(9)			
Health Care Reform And COBRA	**Q1:** Did the health care reform legislation extend the COBRA premium reduction (subsidy)?	**A1:** No. The new health care reform legislation, The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act, did not extend the eligibility time period for the COBRA premium reduction. Eligibility for the subsidy ended May 31, 2010; however, those individuals who become eligible on or before May 31, 2010 can still receive the full 15 months as long as they remain otherwise eligible.	DOL	FAQ Health Care Reform and COBRA	http://www.dol.gov/ebsa/faqs/faq-healthcarereform.html
Health Care Reform And COBRA	**Q2:** Did the health care reform legislation extend the time period I can have COBRA beyond 18 months?	**A2:** No. The new health care reform legislation, The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act, did not extend the maximum time periods of continuation coverage provided by COBRA. COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying	DOL	FAQ Health Care Reform and COBRA	http://www.dol.gov/ebsa/faqs/faq-healthcarereform.html

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		events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage. Individuals who become disabled can extend the 18 month period of continuation coverage for a qualifying event that is a termination of employment or reduction of hours. To qualify for additional months of COBRA continuation coverage, the qualified beneficiary must: Have a ruling from the Social Security Administration that he or she became disabled within the first 60 days of COBRA continuation coverage (or before) and Send the plan a copy of the Social Security ruling letter within 60 days of receipt, but prior to expiration of the 18-month period of coverage. If these requirements are met, the entire family qualifies for an additional 11 months of COBRA continuation coverage. See An Employee's Guide to Health Benefits Under COBRA-The Consolidated Omnibus Budget Reconciliation Act for more information about COBRA.			

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Health Care Reform And COBRA	**Q3:** Did the health care reform legislation eliminate COBRA?	**A3:** No. The new health care reform legislation, The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act, did not eliminate COBRA or change the COBRA rules. See An Employee's Guide to Health Benefits Under COBRA-The Consolidated Omnibus Budget Reconciliation Act for more information about COBRA.	DOL	FAQ Health Care Reform and COBRA	http://www.dol.gov/ebsa/faqs/faq-healthcarereform.html
Health Care Reform And COBRA	**Q4:** How does the new health care reform legislation affect my coverage under my group health plan?	**A4:** The new health care reform legislation, The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act, makes many changes to employee health benefit plans. Some of the changes go into effect for the first plan year that begins on or after six months after enactment (September 23, 2010), so for calendar year plans, January 1, 2011. However, many changes do not go into effect until the first plan year beginning on or after January 1, 2014. • EBSA has developed a dedicated Web page on the new health reform law – the Patient Protection and Affordable Care Act. You can also get to the dedicated Web page from EBSA's Home Page www.dol.gov/ebsa by selecting the first button on the right hand navigation bar.	DOL	FAQ Health Care Reform and COBRA	http://www.dol.gov/ebsa/faqs/faq-healthcarereform.html

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		• EBSA is adding information regarding the new law as it becomes available so we suggest that you subscribe to the page. (There is a subscribe button in the header of the page.) As new information is added such as Frequently Asked Questions, Fact Sheets, and technical guidance you will receive notification by email that the new information is available. • HHS also has a Website addressing many of the questions people have about the new legislation.			
IRC § 7216, Disclosure or Use of Information by Tax Return Preparers	**Q1:** How does IRC § 7216 affect tax return preparers?	**A1:** The IRS takes the privacy rights of America's taxpayers very seriously and is committed to protecting those rights. Section 7216 prohibits tax return preparers, including those who also offer services and education related to the Affordable Care Act, from knowingly or recklessly disclosing or using tax return information for unauthorized purposes. The tax return information a tax return preparer can disclose or use depends on whether the preparer obtains consent from the taxpayer, or whether Treas. Reg. § 301.7216-2 provides an exception to the general prohibition on disclosure or use of tax return information without taxpayer consent.	FAQ IRC 7216	IRS	http://www.irs.gov/uac/IRC-§-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act

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IRC § 7216, Disclosure or Use of Information by Tax Return Preparers	**Q2:** For tax return preparers, will taxpayer consent be required to use contact information to provide clients general educational information about the Affordable Care Act and health insurance available through the new health insurance marketplaces?	**A2:** No. The § 7216 regulations permit tax return preparers to use a list of client names, addresses, email addresses, phone numbers and each client's income tax form number to provide clients general educational information, including general educational information related to the Affordable Care Act. For example, a tax return preparer may mail general educational information to all clients regarding health care enrollment options available through the new health insurance marketplaces without obtaining consent.	FAQ IRC 7216	IRS	http://www.irs.gov/uac/IRC-§-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act
IRC § 7216, Disclosure or Use of Information by Tax Return Preparers	**Q3:** Will taxpayer consent be required to solicit and facilitate client enrollment in health insurance available through the new health insurance marketplaces?	**A3:** Yes. Tax return preparers who use tax return information to solicit and facilitate health care enrollment services must first obtain taxpayer consent to do so. Example: Return Preparer Z is also a health care "navigator" who would like to use tax return information, as defined in Treas. Reg. § 301.7216-1(b)(3), to solicit and facilitate enrollment of eligible clients into qualified health plans available through the new health insurance marketplaces. Z must obtain taxpayer consent following the rules specified in Treasury Regulation § 301.7216-3 prior to using the tax return information in assisting taxpayers in connection with the solicitation and facilitation of the enrollment of Z's eligible clients into qualified health care	FAQ IRC 7216	IRS	http://www.irs.gov/uac/IRC-§-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act

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		plans. See Rev. Proc. 2013-14 (I.R.B. 2013-3, Jan.4, 2013), as modified by Rev. Proc. 2013-19 (I.R.B. 2013-10, March 4, 2013), for requirements for consents from taxpayers who file a return in the Form 1040 series. For information regarding the qualification requirements for health care navigators, agents, or brokers visit healthcare.gov.			
IRC § 7216, Disclosure or Use of Information by Tax Return Preparers	**Q4:** Do consent requirements also apply to volunteer tax return preparers who offer client services related to the Affordable Care Act?	**A4:** Yes. Solicitation to offer health care enrollment services by all tax return preparers, including volunteer preparers, using tax return information, requires taxpayer consent.	FAQ IRC 7216	IRS	http://www.irs.gov/uac/IRC-§-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act
IRC § 7216, Disclosure or Use of Information by Tax Return Preparers	**Q5:** Is specific language required in § 7216 consent?	**A5:** For calendar year 2013, tax return preparers may use either the mandatory language in section 4.04 of Rev. Proc. 2008-35 or the mandatory language in section 5.04 of Rev. Proc. 2013-14 for consents under § 7216 from taxpayers filing a return in the Form 1040 series. Starting Jan.1, 2014, tax return preparers must use the mandatory language in Rev. Proc. 2013-14. See Rev. Proc. 2013-19.	FAQ IRC 7216	IRS	http://www.irs.gov/uac/IRC-§-7216-Questions-and-Answers-Related-to-the-Affordable-Care-Act
Medical Loss Ratio (MLR)	**Q1:** Insurance Company issues health insurance both in the individual	**A1:** MLR rebates paid by Insurance Company, either as cash payments or as premium reductions, are return premiums. Return premiums reduce	FAQ MLRs	IRS	http://www.irs.gov/uac/Medical-Loss-Ratio-(MLR)-FAQs

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	market and the group market during 2011. After determining that it is required to pay MLR rebates on both types of policies issued by Insurance Company during 2011, Insurance Company pays the rebates to the individual policyholders as cash payments in July 2012, and pays the rebates to the group policyholders as premium reductions for coverage in July 2012. What are the federal tax consequences to Insurance Company?	Insurance Company's taxable income. The year in which Insurance Company takes the reduction and whether Insurance Company may take an estimated reserve for the return premium are not addressed by this FAQ. For a cash rebate paid to an individual policyholder, Insurance Company is not required to file a Form 1099-MISC with respect to that payment or furnish a Form 1099-MISC to the individual policyholder unless (1) the total rebate payments made to that policyholder during the year total $600 or more, and (2) Insurance Company knows that the rebate payments constitute taxable income to the individual policyholder or can determine how much of the payments constitute taxable income. If Insurance Company is required to file a Form 1099-MISC with respect to the rebate payment, it must also furnish a copy to the individual policyholder. See Q&As 2 through 4 below for guidance on whether a cash payment or premium reduction constitutes taxable income to an individual policyholder. For a rebate paid to a group policyholder as a premium reduction, Insurance Company is not required to file a Form 1099-MISC or furnish a copy to the group policyholder unless (1) the group policyholder is not an			

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		exempt recipient for Form 1099 purposes, (2) the total rebate payments to that group policyholder during the year total $600 or more, and (3) Insurance Company knows that the rebate payments constitute taxable income to the group policyholder or can determine how much of the payments constitutes taxable income. Exempt recipients for which Forms 1099 generally are not required to be provided include corporations, tax exempt organizations, and federal and state governments. Insurance Company can rely on a recipient's claim of exempt recipient status on a Form W-9; see the Instructions for Form W-9 or the General Instructions for Certain Information Returns. See Q&As 5-14 for guidance on whether a premium reduction or cash payment constitutes taxable income to employees participating in a group health plan. (Q&As 5-9 address after-tax premium payments and Q&As 10-14 address pre-tax payments.)			
Medical Loss Ratio (MLR)	**Q2:** In 2011, Aaron purchased and paid premiums for a health insurance policy for himself. Aaron does not deduct the premium payments on his 2011 Form 1040 and	**A2:** No. The MLR rebate that Aaron receives on July 1, 2012, is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Because Aaron did not deduct the premium payments on his 2011 Form 1040, the rebate is not taxable whether received as a cash payment or applied as a reduction in the amount of premiums due for			

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	does not receive any reimbursement or subsidy for the premiums. Based on his enrollment during 2011, Aaron receives a MLR rebate on July 1, 2012. Is Aaron's MLR rebate subject to federal income tax?	2012.			
Medical Loss Ratio (MLR)	**Q3:** The facts for Beatrice are the same as the facts for Aaron in Question 2 except that she deducts the premium payments on Schedule A of her 2011 Form 1040. Is Beatrice's MLR rebate subject to federal income tax?	**A3:** Yes. The MLR rebate that Beatrice receives on July 1, 2012, is a rebate of part of her 2011 insurance premiums (a purchase price adjustment). Because Beatrice deducted the premium payments on Schedule A of her 2011 Form 1040, the MLR rebate that Beatrice receives on July 1, 2012, is taxable to the extent that she received a tax benefit from the deduction, whether the rebate is received as a cash payment or applied as a reduction in the amount of premiums due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income.			
Medical Loss Ratio (MLR)	**Q4:** The facts for Charlie are the same as the facts for Beatrice in Question	**A4:** Yes. The MLR rebate that Charlie receives on July 1, 2012, is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Because			

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	3, except that Charlie is self-employed so that he deducts the premium payments on line 29 of his 2011 Form 1040. Is Charlie's MLR rebate subject to federal income tax?	Charlie deducted the premium payments on line 29 of his 2011 Form 1040, the MLR rebate that Charlie receives on July 1, 2012, is taxable to the extent that he received a tax benefit from the deduction, whether the rebate is received as a cash payment or as a reduction in the amount of premiums due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Non-Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income.			
Medical Loss Ratio (MLR)	**Q5:** ***assume that the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012)*** In 2011, Daniel participated in his employer's group health plan and received health	**A5:** No. The MLR rebate that Daniel receives in 2012 is a rebate of part of his 2011 insurance premiums (a purchase price adjustment). Daniel paid taxes on his compensation as an employee and used part of the after-tax income to pay his portion of the 2011 premiums. He did not deduct the premiums; therefore, the rebate is not taxable when applied as a reduction in the amount of premiums due for 2012. In addition, because the MLR rebate is a return of amounts that have already been subject to federal employment taxes, the rebate is not subject to federal employment taxes.			

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	coverage under the group health insurance policy purchased directly by his employer under the plan. The plan provides that Daniel's employer pays for 60% of the premium for each employee, and the employee pays for 40% of the premium on an after-tax basis. Daniel does not deduct the premiums on his 2011 Form 1040. On July 1, 2012, Daniel's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year premium for coverage under the group health insurance policy. In accordance with the terms of the group				

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	health plan and consistent with applicable Department of Labor (DOL) guidance, 60% of the rebate is used to reduce the employer portion of the premium due for 2012, and 40% of the rebate is used to reduce the employee portion of the premium due for 2012, but only for participants under the plan who also were participants under the plan during 2011. Because Daniel participated in the plan during 2011 and 2012, he is entitled to a MLR rebate. As a result of the rebate and corresponding premium reduction, Daniel's premium for 2012 coverage under the group health plan is reduced. Is Daniel's MLR rebate income				

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	subject to federal income tax?				
Medical Loss Ratio (MLR)	**Q6:** ***assume that the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012)*** Would Daniel's MLR rebate be subject to federal income tax if the insurance company had paid the MLR rebate in cash and then the employer distributed the MLR rebate in cash to Daniel (consistent with applicable Department of Labor (DOL) guidance) rather than reducing the premiums due for 2012?	**A6:** No. If Daniel receives a cash distribution because of the MLR rebate, the cash also is a reduction in the cost of his 2011 insurance premiums (a purchase price adjustment) and is not taxable. In addition, because the MLR rebate payment is a return of amounts that have already been subject to federal employment taxes, the payment is not subject to federal employment taxes.			

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Medical Loss Ratio (MLR)	**Q7:** ***assume that the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012)*** Would Daniel's MLR rebate be subject to federal income tax if Daniel had deducted his premium payment on his 2011 Form 1040?	**A7:** Yes. If Daniel deducted the premium payments on his 2011 Form 1040 and receives a MLR rebate in 2012, the MLR rebate is taxable to the extent that he received a tax benefit from the deduction, regardless of whether the rebate is provided as a cash payment or a reduction in the premium due for 2012. For more information on determining whether there is a tax benefit from the deduction, see Itemized Deduction Recoveries in Publication 525, Taxable and Nontaxable Income. Because the MLR rebate is a return of amounts that have already been subject to federal employment taxes, the rebate (whether applied to reduce Daniel's 2012 premium or provided as a cash payment) is not subject to federal employment taxes.			
Medical Loss Ratio (MLR)	**Q8:** ***assume that the MLR rebates are provided to all employees participating in a group health plan in the year the MLR rebates are paid (in these examples, 2012), regardless of whether an employee participated in the*	**A8:** No. Doris receives the MLR rebate due to her participation in her employer's group health plan during 2012, and would not have received the MLR rebate had she failed to participate in the plan during 2012. Therefore, the MLR rebate is a purchase price adjustment that reduces the cost of her 2012 insurance premiums and is not taxable regardless of whether Doris deducted the 2011 premium payments on her 2011 Form 1040. If Doris			

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	*plan in the year the employees paid the premiums being rebated (in these examples, 2011)*** In 2011, Doris participated in her employer's group health plan and received health coverage under the group health insurance policy purchased directly by her employer under the plan. The plan provides that Doris's employer pays for 60% of the premium for each employee, and the employee pays for 40% of the premium on an after-tax basis. On July 1, 2012, Doris's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The employer may distribute the MLR	deducts the premiums she pays for health care coverage on her 2012 Form 1040, the amount of the MLR rebate reduces the amount of her deduction because she is paying less for premiums. If Doris had received the MLR rebate in cash, instead of as a premium reduction, Doris's rebate also would not be subject to federal income tax and would reduce the amount of any 2012 deduction for premiums paid by Doris on her Form 1040. In either case, Doris's rebate would not be wages subject to employment taxes.			

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	rebate in cash or in the form of a reduction in the current year premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and the applicable DOL guidance, the employer applies 60% of the MLR rebate to reduce the employer portion of the premium due for 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012 for all participants under the plan, regardless of whether the employee who receives the MLR rebate participated in the plan during 2011. Because Doris participates in the plan during 2012, she is entitled to a MLR rebate. As a result of				

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	the rebate and the corresponding premium reduction, Doris's premium for 2012 coverage under the group health plan is reduced. Is Doris's MLR rebate subject to federal income tax?				
Medical Loss Ratio (MLR)	**Q9:** ***assume that the MLR rebates are provided to all employees participating in a group health plan in the year the MLR rebates are paid (in these examples, 2012), regardless of whether an employee participated in the plan in the year the employees paid the premiums being rebated (in these examples, 2011)*** In 2012, Edwin begins working for the same employer as Doris (and thus he did not participate in the plan during	**A9:** No. The MLR rebate Edwin receives is a purchase price adjustment that reduces the cost of his 2012 insurance premiums and is not taxable. If Edwin deducts the premiums he pays for health care coverage in 2012 on his Form 1040, the amount of the rebate reduces the amount of his deduction because he is paying less for premiums. If Edwin had received the MLR rebate in cash, instead of as a premium reduction, Edwin's rebate also would not be subject to federal income tax and would reduce the amount of any 2012 deduction for premiums paid by Edwin on his Form 1040. In either case, Edwin's rebate would not be wages subject to employment taxes.			

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	2011). Edwin participates in the plan beginning on his first day of employment. When his employer distributes the MLR rebate as a reduction in Edwin's 2012 premiums, Edwin's premium for 2012 coverage under the group health plan is reduced. Is Edwin's MLR rebate subject to federal income tax?				
Medical Loss Ratio (MLR)	**Q10:** ***assume the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012)*** Frances participates	**A10:** Yes. Because the MLR rebate is distributed as a premium reduction, the amount Frances pays for premiums through a salary reduction contribution in 2012 is decreased by $X. Consequently, in 2012 there is a corresponding increase of $X in her taxable salary that is also wages subject to employment taxes.			

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	in her employer's group health plan and receives health coverage under the group health insurance policy purchased directly by her employer under the plan. Frances pays her portion of premiums on a pre-tax basis under her employer's cafeteria plan. The plan provides that Frances's employer pays for 60% of the health insurance premium for each employee, and the employee pays for 40% of the premium. On July 1, 2012, Frances's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year's premium for coverage under the				

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	group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable DOL guidance, the employer applies 60% of the rebate to reduce the employer portion of the premium due for 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012, but only for participants under the plan who also were participants under the plan during 2011. Because Frances participates in the plan during 2011 and 2012, she is entitled to a rebate of $X. As a result of the rebate and corresponding premium reduction, Frances's salary reduction contribution under the cafeteria plan for				

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	2012 is reduced by $X. Is Frances's MLR rebate subject to federal income tax?				
Medical Loss Ratio (MLR)	**Q11:** ***assume the MLR rebates are provided only to employees participating in a group health plan both in the year employees paid the premiums being rebated (in these examples, 2011) and the year the MLR rebates are paid (in these examples, 2012)*** Will Frances also have an $X increase in taxable income during 2012 if the MLR rebate is provided in the form of a cash payment and the employer distributes the MLR rebate to Frances in cash (consistent with applicable DOL guidance) instead of	**A11:** Yes. Frances will have $X more taxable income in 2012. The amount that Frances paid for premiums for health insurance was subtracted from her salary on a pre-tax basis under her employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to Frances of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that Frances receives in 2012 is an increase in taxable income that is also wages subject to employment taxes.			

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	reducing premiums for 2012 coverage?				
Medical Loss Ratio (MLR)	**Q12:** ** *assume the MLR rebates are provided to all employees participating in a group health plan during the year the MLR rebates are paid (in these examples, 2012), regardless of whether the employee who receives the MLR rebate participated in the plan during the plan year covered by the MLR rebate (in these examples, 2011)*** Fred participates during 2011 and 2012 in his employer's group health plan and receives health coverage under the group health insurance policy purchased directly by his employer under the plan. Fred pays	**A12:** Yes. Because the MLR rebate is distributed as a premium reduction, the amount Fred pays for premiums through a salary reduction contribution in 2012 is decreased by $X. Consequently, in 2012 there is a corresponding increase of $X in his taxable salary that is also wages subject to employment taxes.			

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	his portion of premiums on a pre-tax basis under his employer's cafeteria plan. The plan provides that Fred's employer pays for 60% of the health insurance premium for each employee, and the employee pays for 40% of the premium. On July 1, 2012, Fred's employer receives a MLR rebate of part of the 2011 group health insurance policy premiums. The MLR rebate is made in the form of a reduction in the current year's premium for coverage under the group health insurance policy. In accordance with the terms of the group health plan and consistent with applicable DOL guidance, the employer applies				

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	60% of the rebate to reduce the employer portion of the premium due for July 2012, and 40% of the rebate to reduce the employee portion of the premium due for 2012, for all participants in the plan (regardless of whether a participant was also a participant in the plan during 2011). Because Fred participates in the plan during 2012, he is entitled to a rebate of $X. As a result of the rebate and corresponding premium reduction, Fred's salary reduction contribution under the cafeteria plan for 2012 is reduced by $X. Is Fred's MLR rebate subject to federal income tax?				
Medical Loss Ratio	**Q13:** ** *assume the*	**A13:** Yes. Fred will have $X more			

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(MLR)	*MLR rebates are provided to all employees participating in a group health plan during the year the MLR rebates are paid (in these examples, 2012), regardless of whether the employee who receives the MLR rebate participated in the plan during the plan year covered by the MLR rebate (in these examples, 2011)*** Will Fred also have an $X increase in income during 2012 if the MLR rebate is made in the form of a cash payment and the plan distributes the MLR rebate to Fred in cash instead of reducing premiums for 2012 coverage?	taxable income in 2012. The amount that Fred paid for premiums for health insurance was subtracted from his salary on a pre-tax basis under his employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to Fred of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that Fred receives in 2012 results in an increase in taxable income that is also wages subject to employment taxes.			
Medical Loss Ratio (MLR)	**Q14:** ** *assume the MLR rebates are provided to all employees*	**A14:** Yes. Because the MLR rebate is distributed as a premium reduction, the amount George pays for premiums through a salary reduction contribution			

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	*participating in a group health plan during the year the MLR rebates are paid (in these examples, 2012), regardless of whether the employee who receives the MLR rebate participated in the plan during the plan year covered by the MLR rebate (in these examples, 2011)*** George begins working for the same employer as Fred in 2012 (and thus he did not participate in the plan during 2011). He participates in the plan during 2012. As a result of the rebate and corresponding premium reduction, George's salary reduction contribution under the cafeteria plan for July 2012 is reduced by $X.	is decreased by $X. Consequently, there is a corresponding increase of $X in his salary and the additional salary is taxable income that is also wages subject to employment taxes. If George receives an $X cash payment, he will have $X more taxable income in 2012. The amount that George paid for premiums for health insurance was subtracted from his salary on a pre-tax basis under his employer's cafeteria plan because it was used to pay for health insurance premiums. The MLR rebate is a return to George of part of that untaxed compensation that is no longer being used to pay for health insurance. Therefore, the MLR rebate that George receives in 2012 is an increase in taxable income that is also wages subject to employment taxes.			

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	Is George's MLR rebate income subject to federal income tax?				
Small Business Health Care Tax Credit for Small Employers	**Q1:** How will the credit make a difference for you?	**A1:** For tax years 2010 through 2013, the maximum credit is 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities. An enhanced version of the credit will be effective beginning Jan. 1, 2014. Additional information about the enhanced version will be added to IRS.gov as it becomes available. In general, on Jan. 1, 2014, the rate will increase to 50 percent and 35 percent, respectively. Here's what this means for you. If you pay $50,000 a year toward workers' health care premiums – and if you qualify for a 15 percent credit, you save … $7,500. If you save $7,500 a year from tax year 2010 through 2013, that's total savings of $30,000. If, in 2014, you qualify for a slightly larger credit, say 20 percent, your savings go from $7,500 a year to $12,000 a year. Even if you are a small business employer who did not owe tax during the year, you can carry the credit back or forward to other tax years. Also, since the amount of the health insurance premium payments are more than the total credit, eligible small businesses	FAQ Small Business Health Care Tax Credit	IRS	http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers

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		can still claim a business expense deduction for the premiums in excess of the credit. That's both a credit and a deduction for employee premium payments. There is good news for small tax-exempt employers too. The credit is refundable, so even if you have no taxable income, you may be eligible to receive the credit as a refund so long as it does not exceed your income tax withholding and Medicare tax liability. And finally, if you can benefit from the credit this year but forgot to claim it on your tax return there's still time to file an amended return.			
Small Business Health Care Tax Credit for Small Employers	**Q2:** Can you claim the credit?	**A2:** Now that you know how the credit can make a difference for your business, let's determine if you can claim it. To be eligible, you must cover at least 50 percent of the cost of single (not family) health care coverage for each of your employees. You must also have fewer than 25 full-time equivalent employees (FTEs). Those employees must have average wages of less than $50,000 a year. Let us break it down for you even more. You are probably wondering: what IS a full-time equivalent employee.	FAQ Small Business Health Care Tax Credit	IRS	http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers

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		Basically, two half-time workers count as one full-timer. Here is an example, 20 half-time employees are equivalent to 10 full-time workers. That makes the number of FTEs 10 not 20. Now let's talk about average wages. Say you pay total wages of $200,000 and have 10 FTEs. To figure average wages you divide $200,000 by 10 – the number of FTEs – and the result is your average wage. The average wage would be $20,000. Also, the amount of the credit you receive works on a sliding scale. The smaller the business or charity, the bigger the credit. So if you have more than 10 FTEs or if the average wage is more than $25,000, the amount of the credit you receive will be less. If you need assistance determining if your small business or tax exempt organization qualifies for the credit, try this step-by-step guide.			
Small Business Health Care Tax Credit for Small Employers	**Q3:** How do you claim the credit?	**A3:** You must use Form 8941, Credit for Small Employer Health Insurance Premiums, to calculate the credit. For detailed information on filling out this form, see the Instructions for Form 8941. If you are a small business, include the amount as part of the general business	FAQ Small Business Health Care Tax Credit	IRS	http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers

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		credit on your income tax return. If you are a tax-exempt organization, include the amount on line 44f of the Form 990-T, Exempt Organization Business Income Tax Return. You must file the Form 990-T in order to claim the credit, even if you don't ordinarily do so. Don't forget … if you are a small business employer you may be able to carry the credit back or forward. And if you are a tax-exempt employer, you may be eligible for a refundable credit.			
Over the Counter Medicines and Drugs	**Q1:** How are the rules changing for reimbursing the cost of over-the-counter medicines and drugs from health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs)?	**A1:** Section 9003 of the Affordable Care Act established a new uniform standard for medical expenses. Effective Jan. 1, 2011, distributions from health FSAs and HRAs will be allowed to reimburse the cost of over-the-counter medicines or drugs only if they are purchased with a prescription. This new rule does not apply to reimbursements for the cost of insulin, which will continue to be permitted, even if purchased without a prescription.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter Medicines and Drugs	**Q2:** How are the rules changing for distributions from health savings accounts (HSAs) and Archer Medical	**A2:** In accordance with Section 9003 of the Affordable Care Act, only prescribed medicines or drugs (including over-the-counter medicines and drugs that are prescribed) and insulin (even if purchased without a	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs

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	Savings Accounts (Archer MSAs) that are used to reimburse the cost of over-the-counter medicines and drugs?	prescription) will be considered qualifying medical expenses and subject to preferred tax treatment.			
Over the Counter Medicines and Drugs	**Q3:** When will the changes become effective?	**A3:** The changes are effective for purchases of over-the-counter medicines and drugs without a prescription after Dec. 31, 2010. The changes do not affect purchases of over-the-counter medicines and drugs in 2010, even if they are reimbursed after Dec. 31, 2010.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter Medicines and Drugs	**Q4:** How do I prove that I have purchased an over-the-counter medicine or drug with a prescription so that I can get reimbursed from my employer's health FSA or an HRA?	**A4:** If your employer's health FSA or HRA reimburses these expenses, you would provide the prescription (or a copy of the prescription or another item showing that a prescription for the item has been issued) and the customer receipt (or similar third-party documentation showing the date of the sale and the amount of the charge). For example, documentation could consist of a customer receipt issued by a pharmacy that reflects the date of sale and the amount of the charge, along with a copy of the prescription; or it could consist of a customer receipt that identifies the name of the purchaser (or the name of the person for whom the prescription applies), the date and amount of the purchase and an Rx number.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter	**Q5:** How does this	**A5:** The new rule does not apply to	FAQ Over the	IRS	http://www.irs.gov/uac/Affordable-Care-

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Medicines and Drugs	change affect over-the-counter medical devices and supplies?	items for medical care that are not medicines or drugs. Thus, equipment such as crutches, supplies such as bandages, and diagnostic devices such as blood sugar test kits will still qualify for reimbursement by a health FSA or HRA if purchased after Dec. 31, 2010, and a distribution from an HSA or Archer MSA for the cost of such items will still be tax-free, regardless of whether the items are purchased using a prescription.	Counter Medicines and Drugs		Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter Medicines and Drugs	**Q6:** Will I need a prescription to use my health FSA, HRA, HSA or Archer MSA funds for insulin purchases after Dec. 31, 2010?	**A6:** No. You can continue to use your health FSA, HRA, HSA or Archer MSA funds to purchase insulin without a prescription after Dec. 31, 2010.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter Medicines and Drugs	**Q7:** I use health FSA funds for my co-pays and deductibles. Will I still be able to reimburse those expenses with health FSA funds after Dec. 31, 2010?	**A7:** Yes. Co-pays and deductibles continue to be reimbursable from a health FSA after Dec. 31, 2010. Similarly, funds from an HRA can continue to be used for these expenses and a distribution from an HSA or Archer MSA for these purposes will be tax-free.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter Medicines and Drugs	**Q8:** My company gives me two extra months beyond the end of the year to submit claims for health FSA expenses incurred during the	**A8:** Yes. The new restriction on plan reimbursements for the cost of over-the-counter medicines or drugs without a prescription applies only to purchases that are made after 2010.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs

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	year. What happens if I purchase over-the-counter medicines or drugs without a prescription in 2010 but do not submit the claim for those expenses until January 2011? Will they qualify for reimbursement?				
Over the Counter Medicines and Drugs	**Q9:** My company's health FSA includes a provision for a grace period, so that if I don't spend all of the money in my health FSA by Dec. 31 in a given year, I can still use the amount left in my health FSA at the end of the year to reimburse expenses I incur during the first 2 ½ months of the following year. If I buy over-the-counter medicines or drugs without a prescription during the 2 ½ month grace period of 2011, can I still use the amount	**A9:** No. The change applies to purchases made on or after Jan. 1, 2011. Thus, even if your employer's plan includes the 2 ½ month grace period provision, the cost of over-the-counter medicines and drugs purchased without a prescription during the first 2 ½ months of 2011 will not be eligible to be reimbursed by a health FSA.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs

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	left in my health FSA at the end of 2010 to reimburse those expenses?				
Over the Counter Medicines and Drugs	**Q10:** If my health FSA or HRA issues a debit card that I use to pay for over-the-counter medicines or drugs, will I still be able to use the card to purchase over-the-counter medicines or drugs after Dec. 31, 2010?	**A10:** Generally, yes, if you have a prescription for the medicine or drug. For expenses incurred in 2010, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs (whether or not you have a prescription) at pharmacies and from mail order and web-based vendors that sell prescription drugs. Starting after Jan. 15, 2011, you may continue to use an FSA or HRA debit card to purchase over-the-counter medicines or drugs at these vendors, so long as you obtain a prescription for the medicine or drug, the prescription is presented to the pharmacist, and the medication is dispensed by the pharmacist and given an Rx number. For further information, including guidance on purchases of over-the-counter medicines and drugs from health care providers other than pharmacies and mail order and web-based vendors (such as physicians or hospitals), see IRS Notice 2011-5. For guidance on debit card purchases at "90 percent pharmacies," see IRS Notice 2010-59.	FAQ Over the Counter Medicines and Drugs	IRS	http://www.irs.gov/uac/Affordable-Care-Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
Over the Counter	**Q11:** The ACA	**A11:** If you have an HSA or an Archer	FAQ Over the	IRS	http://www.irs.gov/uac/Affordable-Care-

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Medicines and Drugs	removed over-the-counter medicines and drugs from the list of reimbursable qualified medical items if purchased without a prescription. If you have an HSA, Archer MSA, health FSA, or HRA, how will the change in the law affect reporting on Form W-2? Do the reimbursements for items that are not qualified medical expenses need to be included as taxable wages on employees' Forms W-2?	MSA, distributions for expenses that are not qualifying medical expenses (including over-the-counter medicines and drugs purchased without a prescription) will be included in your gross income and subject to an additional tax of 20%. The income tax and additional tax are reported on Form 8889 for an HSA distribution and on Form 8853 for an Archer MSA distribution. You complete these forms and attach them to your Form 1040 when you file your income tax return. Distributions from an HSA or an Archer MSA are not included as taxable wages and do not affect your Form W-2.	Counter Medicines and Drugs		Act:-Questions-and-Answers-on-Over-the-Counter-Medicines-and-Drugs
2013 Changes to Itemized Deduction for Medical Expenses	**Q1:** When do changes to the itemized deduction for medical expenses take effect?	**A1:** The rules are changing if you plan to itemize medical deductions on your 2013 federal tax return that you will file in 2014. The change will not affect income tax returns for the 2012 taxable year that will be filed in 2013.	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses
2013 Changes to Itemized Deduction for Medical Expenses	**Q2:** What amount of my medical expenses can I deduct beginning Jan. 1, 2013?	**A2:** If you and your spouse are both under age 65, on your 2013 tax return that you will file in 2014, you can deduct on Schedule A, Itemized Deductions (Form 1040) only the amount of your unreimbursed allowable medical and dental expenses that is	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses

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		more than 10 percent of your adjusted gross income (AGI) from Form 1040, line 38. If you or your spouse is 65 or over, you are temporarily exempt from the increase. The exemption applies to any tax year beginning after December 31, 2012, and ending before January 1, 2017, if you or your spouse attained age 65 during or before the tax year.			
2013 Changes to Itemized Deduction for Medical Expenses	**Q3:** If I turn 65 in 2014, what threshold percentage should I use?	**A3:** You will file your 2013 tax return – which you will file in 2014 - using the 10 percent threshold of your adjusted gross income. When you turn 65 in 2014, you will file your 2014 tax return in 2015 and will use the 7.5 percent threshold of your adjusted gross income. Beginning with your 2017 tax return (filing in 2018), and thereafter, you will use the 10 percent threshold of your adjusted gross income.	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses
2013 Changes to Itemized Deduction for Medical Expenses	**Q4:** Whose medical expenses can I include?	**A4:** You can generally include medical expenses you pay for yourself, your spouse, and your dependents. IRS Publication 502, Medical and Dental Expenses, contains additional information on medical expenses including how you figure and report the deduction on your return.	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses
2013 Changes to Itemized Deduction for Medical Expenses	**Q5:** How do I figure the deduction if I am under 65?	**A5:** To figure your medical and dental expense deduction on your 2013 tax return that you will file in 2014, follow the instructions to complete lines 1	FAQ 2013 Changes to the Itemized Deduction for	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses

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		through 4 of Schedule A, Form 1040. IRS Publication 502, Medical and Dental Expenses, contains additional information on medical expenses including how you figure and report the deduction on your return.	Medical Expenses		
2013 Changes to Itemized Deduction for Medical Expenses	**Q6:** How do I figure the deduction if I am over 65?	**A6:** To figure your medical and dental expense deduction on your 2013 tax return that you will file in 2014, follow the instructions to complete lines 1 through 4 of Schedule A, Form 1040. IRS Publication 502, Medical and Dental Expenses, and Pub 554, Tax Guide for Seniors, contain additional information on medical expenses including how you figure and report the deduction on your return.	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses
2013 Changes to Itemized Deduction for Medical Expenses	**Q7:** What records should I keep for each medical expense?	**A7:** For each medical expense, you should keep a record of: •The name and address of each medical care provider you paid, and •The amount and date of each payment. You should also keep a statement or itemized invoice showing the following: •A description of the medical care received •Who received the care •The nature and purpose of the medical expenses. Do not send these records with your	FAQ 2013 Changes to the Itemized Deduction for Medical Expenses	IRS	http://www.irs.gov/Individuals/Questions-and-Answers:-2013-Changes-to-the-Itemized-Deduction-for-Medical-Expenses

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		return. IRS Publication 502, Medical and Dental Expenses, contains additional information on medical expenses including how you figure and report the deduction on your return. For additional information, see changes to the itemized deduction for 2013 medical expenses.			
Individual Shared Responsibility Provisions	**Q1:** What is the individual shared responsibility provision?	**A1:** Under the Affordable Care Act, the federal government, state governments, insurers, employers, and individuals are given shared responsibility to reform and improve the availability, quality, and affordability of health insurance coverage in the United States. Starting in 2014, the individual shared responsibility provision calls for each individual to have minimum essential health coverage (known as minimum essential coverage) for each month, qualify for an exemption, or make a payment when filing his or her federal income tax return.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q2:** Who is subject to the individual shared responsibility provision?	**A2:** The provision applies to individuals of all ages, including children. The adult or married couple who can claim a child or another individual as a dependent for federal income tax purposes is responsible for making the payment if the dependent does not have coverage or an exemption.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q3:** When does the individual shared	**A3:** The provision goes into effect on Jan. 1, 2014. It applies to each month in	FAQ Individual Share	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-

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	responsibility provision go into effect?	the calendar year. The amount of any payment owed takes into account the number of months in a given year an individual is without coverage or an exemption.	Responsibility Provision		Responsibility-Provision
Individual Shared Responsibility Provisions	**Q4:** Is transition relief available in certain circumstances?	**A4:** Yes. Notice 2013-42, published on June 26, 2013, provides transition relief from the shared responsibility payment for individuals who are eligible to enroll in eligible employer-sponsored health plans with a plan year other than a calendar year (non-calendar year plans) if the plan year begins in 2013 and ends in 2014 (2013-2014 plan year). The transition relief applies to an employee, or an individual having a relationship to the employee, who is eligible to enroll in a non-calendar year eligible employer-sponsored plan with a 2013-2014 plan year. The transition relief begins in January 2014 and continues through the month in which the 2013-2014 plan year ends.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q5:** What counts as minimum essential coverage?	**A5:** Minimum essential coverage includes the following: •Employer-sponsored coverage (including COBRA coverage and retiree coverage) •Coverage purchased in the individual market •Medicare Part A coverage and Medicare Advantage •Most Medicaid coverage	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		•Children's Health Insurance Program (CHIP) coverage •Certain types of veterans health coverage administered by the Veterans Administration •TRICARE •Coverage provided to Peace Corps volunteers •Coverage under the Nonappropriated Fund Health Benefit Program Minimum essential coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care, Medicaid covering only certain benefits such as family planning, workers' compensation, or disability policies. The Department of Health and Human Services (HHS) has authority to designate additional types of coverage as minimum essential coverage. In final regulations filed at the Federal Register on June 26, 2013, HHS designated Refugee Medical Assistance supported by the Administration for Children and Families and Medicare Advantage plans as minimum essential coverage. HHS also designated state high risk pools and self-funded health coverage offered to students by universities for plan or policy years that begin on or before Dec. 31, 2014 as minimum essential coverage. See 45 CFR § 156.602(a) and (e). For plan or policy years that begin			

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		after Dec. 31, 2014, sponsors of state high risk pools and individual self-funded student health plans may apply to HHS to be recognized as minimum essential coverage through the process outlined in 45 CFR § 156.604.			
Individual Shared Responsibility Provisions	**Q6:** What are the statutory exemptions from the requirement to obtain minimum essential coverage?	**A6:** 1.Religious conscience: You are a member of a religious sect that is recognized as conscientiously opposed to accepting any insurance benefits. The Social Security Administration administers the process for recognizing these sects according to the criteria in the law. 2.Health care sharing ministry: You are a member of a recognized health care sharing ministry. 3.Indian tribes: You are a member of a federally recognized Indian tribe. 4.No filing requirement: Your household income is below the minimum threshold for filing a tax return. The requirement to file a federal tax return depends on your filing status, age, and types and amounts of income. To find out if you are required to file a federal tax return, use the IRS Interactive Tax Assistant (ITA). 5.Short coverage gap: You went without coverage for less than three consecutive months during the year. For more	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		information see question 22. 6.Hardship: A Health Insurance Marketplace, also known as an Affordable Insurance Exchange, has certified that you have suffered a hardship that makes you unable to obtain coverage. 7.Unaffordable coverage options: You can't afford coverage because the minimum amount you must pay for the premiums is more than eight percent of your household income. 8.Incarceration: You are in a jail, prison, or similar penal institution or correctional facility after the disposition of charges against you. 9.Not lawfully present: You are neither a U.S. citizen, a U.S. national, nor an alien lawfully present in the U.S.			
Individual Shared Responsibility Provisions	**Q7:** What do I need to do if I want to be sure I have minimum essential coverage or an exemption for 2014?	**A7:** Most individuals in the United States have health coverage today that will count as minimum essential coverage and will not need to do anything more than continue the coverage that they have. For those who do not have coverage, who anticipate discontinuing the coverage they have currently, or who want to explore whether more affordable options are available, Health Insurance Marketplaces (also known as Affordable	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		Insurance Exchanges) will open for every state and the District of Columbia in October of 2013. These Health Insurance Marketplaces will help qualified individuals find minimum essential coverage that fits their budget and potentially financial assistance to help with the costs of coverage beginning in 2014. The Health Insurance Marketplace will also be able to assess whether applicants are eligible for Medicaid or the Children's Health Insurance Program (CHIP). For those who will become eligible for Medicare during 2013, enrolling for Medicare will also ensure that you have minimum essential coverage for 2014. For those seeking an exemption, a Health Insurance Marketplace will be able to provide certificates of exemption for many of the exemption categories. HHS has proposed regulations on how a Health Insurance Marketplace will go about granting these exemptions. Individuals will also be able to claim certain exemptions for 2014 when they file their federal income tax returns in 2015. Individuals who are not required to file a federal income tax return are automatically exempt and do not need to take any further action to secure an exemption. See question 21 for further information on exemptions.			

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		For more information about the Health Insurance Marketplace, including how to sign up for email updates and tips on how to prepare for open enrollment in October 2013, visit the Health Insurance Marketplace website.			
Individual Shared Responsibility Provisions	**Q8:** Is more detailed information available about the individual shared responsibility provision?	**A8:** Yes. Treasury and the IRS have proposed regulations on the new individual shared responsibility provision.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q9:** Are children subject to the individual shared responsibility provision?	**A9:** Yes. Each child must have minimum essential coverage or qualify for an exemption for each month in the calendar year. Otherwise, the adult or married couple who can claim the child as a dependent for federal income tax purposes will owe a payment.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q10:** Are senior citizens subject to the individual shared responsibility provision?	**A10:** Yes. Senior citizens must have minimum essential coverage or qualify for an exemption for each month in a calendar year. Senior citizens will have minimum essential coverage for every month they are enrolled in Medicare.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q11:** Are all individuals living in the United States subject to the individual shared responsibility provision?	**A11:** All citizens are subject to the individual shared responsibility provision as are all permanent residents and all foreign nationals who are in the United States long enough during a calendar year to qualify as resident aliens for tax purposes. Foreign nationals who live in the United States for a short enough period that they do not become resident aliens for federal	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		income tax purposes are not subject to the individual shared responsibility payment even though they may have to file a US income tax return. The IRS has more information available on when a foreign national becomes a resident alien for federal income tax purposes.			
Individual Shared Responsibility Provisions	**Q12:** Are US citizens living abroad subject to the individual shared responsibility provision?	**A12:** Yes. However, US citizens who live abroad for a calendar year (or at least 330 days within a 12 month period) are treated as having minimum essential coverage for the year (or period). These are individuals who qualify for an exclusion from income under section 911 of the Code. See Publication 54 for further information on the section 911 exclusion. They need take no further action to comply with the individual shared responsibility provision.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q13:** Are residents of the territories subject to the individual shared responsibility provision?	**A13:** All bona fide residents of the United States territories are treated by law as having minimum essential coverage. They are not required to take any action to comply with the individual shared responsibility provision.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q14:** If I receive my coverage from my spouse's employer, will I have minimum essential coverage?	**A14:** Yes. Employer-sponsored coverage is generally minimum essential coverage. (See question 5 for information on specialized types of coverage that are not minimum essential coverage.) If an employee enrolls in employer-sponsored coverage for himself and his family, the employee	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		and all of the covered family members have minimum essential coverage.			
Individual Shared Responsibility Provisions	**Q15:** Do my spouse and dependent children have to be covered under the same policy or plan that covers me?	**A15:** No. You, your spouse and your dependent children do not have to be covered under the same policy or plan. However, you, your spouse and each dependent child for whom you may claim a personal exemption on your federal income tax return must have minimum essential coverage or qualify for an exemption, or you will owe a payment when you file.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q16:** My employer tells me that our company's health plan is "grandfathered." Does my employer's plan provide minimum essential coverage?	**A16:** Yes. Grandfathered group health plans provide minimum essential coverage.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q17:** I am a retiree, and I am too young to be eligible for Medicare. I receive my health coverage through a retiree plan made available by my former employer. Is the retiree plan minimum essential coverage?	**A17:** Yes. Retiree health plans are generally minimum essential coverage.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q18:** I work for a local government	**A18:** Yes. Employer-sponsored coverage is minimum essential coverage	FAQ Individual Share	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-

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	that provides me with health coverage. Is my coverage minimum essential coverage?	regardless of whether the employer is a governmental, nonprofit, or for-profit entity.	Responsibility Provision		Responsibility-Provision
Individual Shared Responsibility Provisions	**Q19:** Do I have to be covered for an entire calendar month in order to get credit for having minimum essential coverage for that month?	**A19:** No. You will be treated as having minimum essential coverage for a month as long as you have coverage for at least one day during that month.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q20:** If I change health coverage during the year and end up with a gap when I am not covered, will I owe a payment?	**A20:** Individuals are treated as having minimum essential coverage for a calendar month if they have coverage for at least one day during that month. Additionally, as long as the gap in coverage is less than three months, you may qualify for an exemption and not owe a payment. See question 22 for more information on the exemption for short coverage gaps.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q21:** If I think I qualify for an exemption, how do I claim it?	**A21:** It depends upon which exemption it is. •The religious conscience exemption and most hardship exemptions are available only by going to a Health Insurance Marketplace, also known as an Affordable Insurance Exchange, and applying for an exemption certificate. Information on final rules for obtaining these exemptions is available. •The exemptions for members of Indian	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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		tribes, members of health care sharing ministries, and individuals who are incarcerated are available either by going to a Marketplace or Exchange and applying for an exemption certificate or by claiming the exemption as part of filing a federal income tax return. •The exemptions for unaffordable coverage, short coverage gaps, certain hardships and individuals who are not lawfully present in the United States can be claimed only as part of filing a federal income tax return. The exemption for those under the federal income tax return filing threshold is available automatically. No special action is needed.			
Individual Shared Responsibility Provisions	**Q22:** What qualifies as a short coverage gap?	**A22:** In general, a gap in coverage that lasts less than three months qualifies as a short coverage gap. If an individual has two short coverage gaps during a year, the short coverage gap exemption only applies to the first or earlier gap.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q23:** If my income is so low that I am not required to file a federal income tax return, do I need to do anything special to claim an exemption from the individual shared responsibility provision?	**A23:** No. Individuals who are not required to file a tax return for a year are automatically exempt from owing a shared responsibility payment for that year and do not need to take any further action to secure an exemption. Individuals who are not required to file a tax return for a year, but file anyway, will be able to claim the exemption on their tax return.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

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Individual Shared Responsibility Provisions	**Q24:** Will I have to do something on my federal income tax return to show that I had coverage or an exemption?	**A24:** The individual shared responsibility provision goes into effect in 2014. You will not have to account for coverage or exemptions or to make any payments until you file your 2014 federal income tax return in 2015. Information will be made available later about how the income tax return will take account of coverage and exemptions. Insurers will be required to provide everyone that they cover each year with information that will help them demonstrate they had coverage.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
Individual Shared Responsibility Provisions	**Q25:** What happens if I do not have minimum essential coverage or an exemption, and I cannot afford to make the payment with my tax return?	**A25:** The IRS routinely works with taxpayers who owe amounts they cannot afford to pay. The law prohibits the IRS from using liens or levies to collect any payment you owe related to the individual responsibility provision, if you, your spouse or a dependent included on your tax return does not have minimum essential coverage. However, if you owe a shared responsibility payment, the IRS may offset that liability against any tax refund you may be due.	FAQ Individual Share Responsibility Provision	IRS	http://www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision
ACA Section 1341 Transitional Reinsurance Program	**Q1:** How may a health insurance issuer treat the contributions under the Reinsurance Program?	**A1:** Health insurance issuers will be able to treat contributions under the Reinsurance Program as ordinary and necessary expenses paid or incurred in carrying on a trade or business, subject to any applicable disallowances or limitations, or as a reduction to taxable income as provided under Subchapter L.	FAQ Transitional Reinsurance Program	IRS	http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs

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ACA Section 1341 Transitional Reinsurance Program	**Q2:** May a sponsor of a self-insured group health plan treat contributions under the Reinsurance Program as ordinary and necessary business expenses?	**A2:** Yes. A sponsor of a self-insured group health plan that pays Reinsurance Program contributions may treat the contributions as ordinary and necessary business expenses, subject to any applicable disallowances or limitations under the Code. This treatment applies whether the contributions are made directly or through a third-party administrator or administrative-services-only contractor. If a plan pays Reinsurance Program contributions directly or through a third-party administrator, as may happen, for example, in the case of a multiemployer plan or a plan funded through a voluntary employees' beneficiary association, the employer or employers contributing to the plan would be permitted to deduct their contributions to the plan, subject to any generally applicable disallowances or limitations.	FAQ Transitional Reinsurance Program	IRS	http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q1:** What are the Employer Shared Responsibility provisions?	**A1:** Starting in 2014, employers employing at least a certain number of employees (generally 50 full-time employees and full-time equivalents, explained more fully below) will be subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (added to the Code by the Affordable Care Act). Under these provisions, if these employers do not offer affordable health coverage that provides a minimum level of coverage to their full-	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		time employees, they may be subject to an Employer Shared Responsibility payment if at least one of their full-time employees receives a premium tax credit for purchasing individual coverage on one of the new Affordable Insurance Exchanges. To be subject to these Employer Shared Responsibility provisions, an employer must have at least 50 full-time employees or a combination of full-time and part-time employees that is equivalent to at least 50 full-time employees (for example, 100 half-time employees equals 50 full-time employees). As defined by the statute, a full-time employee is an individual employed on average at least 30 hours per week (so half-time would be 15 hours per week).			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q2:** When do the Employer Shared Responsibility provisions go into effect?	**A2:** The Employer Shared Responsibility provisions generally go into effect on Jan. 1, 2014. Employers will use information about the employees they employ during 2013 to determine whether they employ enough employees to be subject to these new provisions in 2014. See question 4 for more information on determining whether an employer is subject to the Employer Shared Responsibility provisions.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared	**Q3:** Is more detailed	**A3:** Yes. Treasury and the IRS have	FAQ Employer	IRS	http://www.irs.gov/uac/Newsroom/Quest

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Responsibility Provisions Under the Affordable Care Act	information available about the Employer Shared Responsibility provisions?	proposed regulations on the new Employer Shared Responsibility provisions. Comments on the proposed regulations may be submitted by mail, electronically, or hand-delivered, and are due by March 18, 2013.	Shared Responsibility Payment		ions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q4:** I understand that the employer shared responsibility provisions apply only to employers employing at least a certain number of employees? How does an employer know whether it employs enough employees to be subject to the provisions?	**A4:** To be subject to the Employer Shared Responsibility provisions, an employer must employ at least 50 full-time employees or a combination of full-time and part-time employees that equals at least 50 (for example, 40 full-time employees employed 30 or more hours per week on average plus 20 half-time employees employed 15 hours per week on average are equivalent to 50 full-time employees). Employers will determine each year, based on their current number of employees, whether they will be considered a large employer for the next year. For example, if an employer has at least 50 full-time employees, (including full-time equivalents) for 2013, it will be considered a large employer for 2014. Employers average their number of employees across the months in the year to see whether they meet the large employer threshold. The averaging can take account of fluctuations that many employers may experience in their work force across the year. For those employers that may be close to the 50 full-time employee (or equivalents)	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		threshold and need to know what to do for 2014, special transition relief is available to help them count their employees in 2013. See question 19 below for information about this transition relief. The proposed regulations provide additional information about how to determine the average number of employees for a year, including information about how to take account of salaried employees who may not clock their hours and a special rule for seasonal workers.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q5:** If two or more companies have a common owner or are otherwise related, are they combined for purposes of determining whether they employ enough employees to be subject to the Employer Shared Responsibility provisions?	**A5:** Yes, consistent with longstanding standards that apply for other tax and employee benefit purposes, companies that have a common owner or are otherwise related generally are combined together for purposes of determining whether or not they employ at least 50 full-time employees (or an equivalent combination of full-time and part-time employees). If the combined total meets the threshold, then each separate company is subject to the Employer Shared Responsibility provisions, even those companies that individually do not employ enough employees to meet the threshold. (The rules for combining related employers do not apply for purposes of determining whether an employer owes an Employer Shared Responsibility payment or the amount of any payment). The proposed regulations provide	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		information on the rules for determining whether companies are related and how they are applied for purposes of the Employer Shared Responsibility provisions.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q6:** Do the Employer Shared Responsibility provisions apply only to large employers that are for-profit businesses or to other large employers as well?	**A6:** All employers that employ at least 50 full-time employees or an equivalent combination of full-time and part-time employees are subject to the Employer Shared Responsibility provisions, including for-profit, non-profit and government entity employers.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q7:** Which employers are not subject to the Employer Shared Responsibility provisions?	**A7:** Employers who employ fewer than 50 full-time employees (or the equivalent combination of full-time and part-time employees) are not subject to the Employer Shared Responsibility provisions. An employer with at least 50 full-time employees (or equivalents) will not be subject to an Employer Shared Responsibility payment if the employer offers affordable health coverage that provides a minimum level of coverage to its full-time employees.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q8:** Are companies with employees working outside the United States subject to the Employer Shared Responsibility provisions?	**A8:** For purposes of determining whether an employer meets the 50 full-time employee (or full-time employees and full-time employee equivalents) threshold, an employer generally will take into account only work performed in the United States. For example, if a foreign employer has a large workforce	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		worldwide, but less than 50 full-time (or equivalent) employees in the United States, the foreign employer generally would not be subject to the Employer Shared Responsibility provisions.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q9:** Are companies that employ U.S. citizens working abroad subject to the Employer Shared Responsibility provisions?	**A9:** A company that employs U.S. citizens working abroad generally would be subject to the Employer Shared Responsibility provisions only if the company had at least 50 full-time employees (or the equivalent combination of full-time and part-time employees), determined by taking into account only work performed in the United States. Accordingly, employees working only abroad, whether or not U.S. citizens, generally will not be taken into account for purposes of determining whether an employer meets the 50 full-time employee (or equivalents) threshold. Furthermore, for employees working abroad the time spent working for the employer outside of the U.S. would not be taken into account for purposes of determining whether the employer owes an Employer Shared Responsibility payment or the amount of any such payment.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q10:** Under what circumstances will an employer owe an Employer Shared Responsibility payment?	**A10:** In 2014, if an employer meets the 50 full-time employee threshold, the employer generally will be liable for an Employer Shared Responsibility payment only if:	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		(a) The employer does not offer health coverage or offers coverage to less than 95% of its full-time employees, and at least one of the full-time employees receives a premium tax credit to help pay for coverage on an Exchange; OR (b) The employer offers health coverage to at least 95% of its full-time employees, but at least one full-time employee receives a premium tax credit to help pay for coverage on an Exchange, which may occur because the employer did not offer coverage to that employee or because the coverage the employer offered that employee was either unaffordable to the employee (see question 11, below) or did not provide minimum value (see question 12, below). After 2014, the rule in paragraph (a) applies to employers that do not offer health coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q11:** How does an employer know whether the coverage it offers is affordable?	**A11:** If an employee's share of the premium for employer-provided coverage would cost the employee more than 9.5% of that employee's annual household income, the coverage is not considered affordable for that employee.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		If an employer offers multiple healthcare coverage options, the affordability test applies to the lowest-cost option available to the employee that also meets the minimum value requirement (see question 12, below.) Because employers generally will not know their employees' household incomes, employers can take advantage of one of the affordability safe harbors set forth in the proposed regulations. Under the safe harbors, an employer can avoid a payment if the cost of the coverage to the employee would not exceed 9.5% of the wages the employer pays the employee that year, as reported in Box 1 of Form W-2, or if the coverage satisfies either of two other design-based affordability safe harbors.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q12:** How does an employer know whether the coverage it offers provides minimum value?	**A12:** A plan provides minimum value if it covers at least 60 percent of the total allowed cost of benefits that are expected to be incurred under the plan. The Department of Health and Human Services (HHS) and the IRS have produced a minimum value calculator. By entering certain information about the plan, such as deductibles and co-pays, into the calculator employers can get a determination as to whether the plan provides minimum value. Additionally, on April 30, 2013, the Treasury Department and the IRS issued proposed regulations regarding the other	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		methods available to determine minimum value. [Updated 5/14/13]			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q13:** If an employer wants to be sure it is offering coverage to all of its full-time employees, how does it know which employees are full-time employees? Does the employer need to offer the coverage to all of its employees because it won't know for certain whether an employee is a full-time employee for a given month until after the month is over and the work has been done?	**A13:** The proposed regulations provide a method to employers for determining in advance whether or not an employee is to be treated as a full-time employee, based on the hours of service credited to the employee during a previous period. Using this look-back method to measure hours of service, the employer will know the employee's status as a full-time employee at the time the employer would offer coverage. The proposed regulations are consistent with IRS notices that have previously been issued and describe approaches that can be used for various circumstances, such as for employees who work variable hour schedules, seasonal employees, and teachers who have time off between school years.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q14:** If an employer that does not offer coverage or offers coverage to less than 95% of its employees owes an Employer Shared Responsibility payment, how is the amount of the payment calculated?	**A14:** In 2014, if an employer employs enough employees to be subject to the Employer Shared Responsibility provisions and does not offer coverage during the calendar year to at least 95% of its full-time employees, it owes an Employer Shared Responsibility payment equal to the number of full-time employees the employer employed for the year (minus 30) multiplied by $2,000, as long as at least one full-time employee receives the premium tax	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		credit. (Note that for purposes of this calculation, a full-time employee does not include a full-time equivalent). For an employer that offers coverage for some months but not others during the calendar year, the payment is computed separately for each month for which coverage was not offered. The amount of the payment for the month equals the number of full-time employees the employer employed for the month (minus up to 30) multiplied by 1/12 of $2,000. If the employer is related to other employers (see question 5 above), then the 30-employee exclusion is allocated among all the related employers. The payment for the calendar year is the sum of the monthly payments computed for each month for which coverage was not offered. After 2014, these rules apply to employers that do not offer coverage or that offer coverage to less than 95% of their full time employees and the dependents of those employees.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q15:** If an employer offers coverage to at least 95% of its employees, and, nevertheless, owes the Employer Shared Responsibility payment, how is the amount of the payment calculated?	**A15:** For an employer that offers coverage to at least 95% of its full-time employees in 2014, but has one or more full-time employees who receive a premium tax credit, the payment is computed separately for each month. The amount of the payment for the month equals the number of full-time employees who receive a premium tax credit for that month multiplied by 1/12	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		of $3,000. The amount of the payment for any calendar month is capped at the number of the employer's full-time employees for the month (minus up to 30) multiplied by 1/12 of $2,000. (The cap ensures that the payment for an employer that offers coverage can never exceed the payment that employer would owe if it did not offer coverage). After 2014, these rules apply to employers that offer coverage to at least 95% of full time employees and the dependents of those employees.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q16:** How will an employer know that it owes an Employer Shared Responsibility payment?	**A16:** The IRS will contact employers to inform them of their potential liability and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. The contact for a given calendar year will not occur until after employees' individual tax returns are due for that year claiming premium tax credits and after the due date for employers that meet the 50 full-time employee (plus full-time equivalents) threshold to file the information returns identifying their full-time employees and describing the coverage that was offered (if any).	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q17:** How will an employer make an Employer Shared Responsibility payment?	**A17:** If it is determined that an employer is liable for an Employer Shared Responsibility payment after the employer has responded to the initial IRS contact, the IRS will send a notice	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		and demand for payment. That notice will instruct the employer on how to make the payment. Employers will not be required to include the Employer Shared Responsibility payment on any tax return that they file.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q18:** I understand that the Employer Shared Responsibility provisions do not go into effect until 2014. However, the health plan that I offer to my employees runs on a fiscal plan year that starts in 2013 and will run into 2014. Do I need to make sure my plan complies with these new requirements in 2013 when the next fiscal plan year starts?	**A18:** For an employer that as of Dec. 27, 2012, already offers health coverage through a plan that operates on a fiscal year (a fiscal year plan), transition relief is available. First, for any employees who are eligible to participate in the plan under its terms as of Dec. 27, 2012 (whether or not they take the coverage), the employer will not be subject to a potential payment until the first day of the fiscal plan year starting in 2014. Second, if (a) the fiscal year plan (including any other fiscal year plans that have the same plan year) was offered to at least one third of the employer's employees (full-time and part-time) at the most recent open season or (b) the fiscal year plan covered at least one quarter of the employer's employees, then the employer also will not be subject to the Employer Shared Responsibility payment with respect to any of its full-time employees until the first day of the fiscal plan year starting in 2014, provided that those full-time employees are offered affordable coverage that provides minimum value no later than that first day. So, for example, if during	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		the most recent open season preceding Dec. 27, 2012, an employer offered coverage under a fiscal year plan with a plan year starting on July 1, 2013 to at least one third of its employees (meeting the threshold for the additional relief), the employer could avoid liability for a payment if, by July 1, 2014, it expanded the plan to offer coverage satisfying the Employer Shared Responsibility provisions to the full-time employees who had not been offered coverage. For purposes of determining whether the plan covers at least one quarter of the employer's employees, an employer may look at any day between Oct. 31, 2012, and Dec. 27, 2012.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q19:** Is transition relief available to help employers that are close to the 50 full-time employee threshold determine their options for 2014?	**A19:** Yes. Rather than being required to use the full twelve months of 2013 to measure whether it has 50 full-time employees (or an equivalent number of part-time and full-time employees), an employer may measure using any six-consecutive-month period in 2013. So, for example, an employer could use the period from Jan. 1, 2013, through June 30, 2013, and then have six months to analyze the results, determine whether it needs to offer a plan, and, if so, choose and establish a plan.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q20:** When can an employee receive a premium tax credit?	**A20:** Premium tax credits generally are available to help pay for coverage for employees who	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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		•are between 100% and 400% of the federal poverty level and enroll in coverage through an Affordable Insurance Exchange, •are not eligible for coverage through a government-sponsored program like Medicaid or CHIP, and •are not eligible for coverage offered by an employer or are eligible only for employer coverage that is unaffordable or that does not provide minimum value.			
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q21:** If an employer does not employ enough employees to be subject to the Employer Shared Responsibility provisions, does that affect the employer's employees' eligibility for a premium tax credit?	**A21:** No. The rules for how eligibility for employer-sponsored insurance affects eligibility for the premium tax credit are the same, regardless of whether the employer employs enough employees to be subject to the Employer Shared Responsibility provisions.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q22:** Where can employees get more information about Affordable Insurance Exchanges?	**A22:** The Department of Health and Human Services is developing the rules for exchanges.	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act
Employer Shared Responsibility Provisions Under the Affordable Care Act	**Q23:** The Treasury Department and the IRS have proposed regulations on the Employer Shared Responsibility provisions that are	**A23:** Yes. Taxpayers may rely on the proposed regulations for purposes of compliance with the Employer Shared Responsibility provisions. If the final regulations are more restrictive than the guidance in the proposed regulations, the final regulations will be applied	FAQ Employer Shared Responsibility Payment	IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act

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	proposed to be effective for months after Dec. 31, 2013. However, there are certain decisions and actions employers may have to take during 2013 to prepare for 2014. May employers rely on the proposed regulations during 2013 for guidance on the Employer Shared Responsibility provisions?	prospectively, and employers will be given sufficient time to come into compliance with the final regulations.			
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q1:** What is the Patient-Centered Outcomes Research Trust Fund fee?	**A1:** The Patient-Centered Outcomes Research Trust Fund fee is a fee on issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI). The institute will assist, through research, patients, clinicians, purchasers and policy-makers, in making informed health decisions by advancing the quality and relevance of evidence-based medicine. The institute will compile and distribute comparative clinical effectiveness research findings.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376	**Q2:** When does the PCORI fee go into effect?	**A2:** The PCORI fee applies to specified health insurance policies with policy years ending after Sept. 30, 2012, and	FAQ Patient-Centered Outcomes	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

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and 4377)		before Oct.1, 2019, and applicable self-insured health plans with plan years ending after Sept. 30, 2012, and before Oct. 1, 2019.	Research Institute		
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q3:** How much is the PCORI fee?	**A3:** The amount of the PCORI fee is equal to the average number of lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. For policy and plan years ending after Sept. 30, 2012, and before Oct. 1, 2013, the applicable dollar amount is $1. For policy and plan years ending after Sept. 30, 2013, and before Oct.1, 2014, the applicable dollar amount is $2. For policy and plan years beginning on or after Oct. 1, 2014, and before Oct. 1, 2019, the applicable dollar amount is further adjusted to reflect inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q4:** How does an issuer of a specified health insurance policy or plan sponsor of an applicable self-insured health plan determine the average number of lives covered under the policy or plan in order to calculate the	**A4:** The PCORI fee is imposed on an issuer of a specified health insurance policy and a plan sponsor of an applicable self-insured health plan based on the average number of lives covered under the policy for the policy year or the plan for the plan year. The PCORI fee final regulations were published on Dec. 6, 2012. The final regulations require issuers of specified health insurance policies to use one of	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

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	PCORI fee for the year?	four alternative methods — the actual count method, the snapshot method, the member months method or the state form method — to determine the average number of lives covered under a specified health insurance policy for a policy year. The final regulations require plan sponsors of applicable health plans to use one of three alternative methods — the actual count method, the snapshot method or the Form 5500 method — to determine the average number of lives covered under the applicable self-insured health plan for a plan year. The final regulations explain the available methods in detail.			
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q5:** Which individuals are taken into account for determining the lives covered under a specified health insurance policy or applicable self-insured health plan?	**A5:** Generally, all individuals who are covered during the policy year or plan year must be counted in computing the average number of lives covered for that year. Thus, for example, an applicable self-insured health plan must count an employee and his dependent child as two separate covered lives unless the plan is a health reimbursement arrangement (HRA) or flexible spending arrangement (FSA).	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q6:** If an employer provides COBRA coverage or otherwise provides coverage to its	**A6:** Yes. These covered individuals and their beneficiaries must be taken into account in calculating the average number of lives covered.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

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	retirees or other former employees, do covered individuals (and their beneficiaries) count as 'lives covered' for purpose of calculating the PCORI fee?				
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q7:** Who is responsible for reporting and paying the PCORI fee?	**A7:** Issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans are responsible for reporting and paying the PCORI fee.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q8:** What form will be used to report and pay the PCORI fee?	**A8:** Issuers of specified health insurance policies and plan sponsors of applicable self-insured health plans will file annually Form 720, Quarterly Federal Excise Tax Return, to report and pay the PCORI fee. The Form 720 will be due on July 31 of the year following the last day of the policy year or plan year. Electronic filing is available but not required. Payment will be due at the time the Form 720 is due. Deposits are not required for the PCORI fee. Issuers and plan sponsors who are required to pay the PCORI fee but are not required to report any other liabilities on a Form 720 will be required to file a Form 720 only once a year. They will not be required to file a Form 720 for the other quarters of the	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

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		year. Issuers and plan sponsors who are required to pay the PCORI fee as well as other liabilities on a Form 720 will use their Form 720 for the 2nd quarter to report and pay the PCORI fee that is due July 31. Only one Form 720 should be filed for each quarter. Form 720 was revised to provide for the reporting and payment of the PCORI fee.			
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q9:** What exceptions to the PCORI fee apply?	**A9:** The PCORI fee does not apply to exempt governmental programs, including Medicare, Medicaid, Children's Health Insurance Program (CHIP) and any program established by federal law for providing medical care (other than through insurance policies) to members of the Armed Forces, veterans and members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act). Also, health insurance policies and self-insured plans that provide only excepted benefits, such as plans that offer benefits limited to vision or dental benefits and most flexible spending arrangements (FSAs), are not subject to the PCORI fee. Further, health insurance policies or self-insured plans that are limited to employee assistance programs, disease	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

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		management programs or wellness programs are not subject to the PCORI fee if these programs do not provide significant benefits in the nature of medical care or treatment. The PCORI fee applies only to policies and plans that cover individuals residing in the United States. Thus, the PCORI fee does not apply to policies and plans that are designed specifically to cover employees who are working and residing outside the United States.			
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q10:** Are health insurance policies or self-insured health plans for tax-exempt organizations or governmental entities subject to the PCORI fee?	**A10:** Yes. Unless the health insurance policy or self-insured health plan is an exempt governmental program described above, the policy or plan is a specified health insurance policy or applicable self-insured health plan subject to the PCORI fee and, accordingly, the health insurance issuer or plan sponsor is responsible for the PCORI fee.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Patient-Centered Outcomes Research Trust Fund Fee (IRC 4375, 4376 and 4377)	**Q11:** When does the PCORI fee expire?	**A11:** The PCORI fee is effective for policy and plan years ending after Sept. 30, 2012, and before Oct. 1, 2019.	FAQ Patient-Centered Outcomes Research Institute	IRS	http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers
Retiree Drug Subsidies	**Q1:** A plan sponsor's taxable year and plan year each begin on January 1 and end on December 31. The sponsor incurs and	**A1:** The plan sponsor incurs the costs in taxable year 2012, before the amendment to § 139A is effective. The deductibility of these costs is governed by the law in effect in 2012. The sponsor may disregard the RDS	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy

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	deducts costs for 2012 and receives RDS payments for part of these costs in 2013. How do the RDS payments affect the amount of the deduction for the costs incurred in 2012?	payments in determining the amount allowable as a deduction for costs incurred in 2012.			
Retiree Drug Subsidies	**Q2:** The facts are the same as in Question 1, except that the plan sponsor incurs and deducts the costs for 2013 and receives RDS payments for part of these costs in 2014. How do the RDS payments affect the amount allowable as a deduction for the costs incurred in 2013?	**A2:** The plan sponsor incurs the costs in taxable year 2013, after the amendment to § 139A is effective. The deductibility of these costs is governed by the law in effect in 2013. The sponsor may not disregard the RDS payments it has a right to receive in determining the amount allowable as a deduction for costs incurred in 2013. The sponsor must, therefore, reduce the amount of its deduction for the costs in 2013 by the amount of the RDS payments it has a right to receive.	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy
Retiree Drug Subsidies	**Q3:** A plan sponsor's taxable year begins on October 1 and ends on September 30. The sponsor's plan year begins on January 1 and ends on December 31. The sponsor incurs and deducts costs for	**A3a:** The 2012 Plan Year. Costs the plan sponsor incurs for the 2012 plan year (January 1 to December 31, 2012) are incurred in part in the taxable year beginning October 1, 2011, and in part in the taxable year beginning October 1, 2012. The amendment to § 139A applies to taxable years beginning after December 31, 2012. The sponsor's costs for the 2012 plan year are incurred	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy

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	2012 and 2013. The sponsor receives RDS payments for the 2012 plan year in 2013 and for the 2013 plan year in 2014. How do the RDS payments affect the amount allowable as a deduction for the costs incurred in 2012 and 2013?	in two taxable years, both beginning before January 1, 2013. Therefore, the sponsor's deductions are governed by the law in effect in 2012. The sponsor may disregard the RDS payments it receives in 2013 in determining the amount allowable as a deduction for costs incurred during the 2012 plan year.			
Retiree Drug Subsidies		**A3b:** The 2013 Plan Year. Costs the plan sponsor incurs for the 2013 plan year (January 1 to December 31, 2013) are incurred in part in the taxable year beginning October 1, 2012, and in part in the taxable year beginning October 1, 2013. Costs the sponsor incurs for the period January 1, 2013, to September 30, 2013, are incurred in the taxable year beginning October 1, 2012. The deductibility of these costs is governed by the law in effect in 2012, and the sponsor may disregard the RDS payments it receives in 2014 in determining the amount allowable as a deduction for costs incurred in the period January 1, 2013 to September 30, 2013. Costs the sponsor incurs for the period October 1, 2013, to December 31, 2013, are incurred in the taxable year beginning October 1, 2013. The	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy

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		deductibility of these costs is governed by the law in effect in 2013. The sponsor must reduce the amount of its deduction for costs incurred during this period by the amount of the RDS payments it has a right to receive for costs incurred in the period October 1, 2013, to December 31, 2013.			
Retiree Drug Subsidies	**Q4:** A plan sponsor's taxable year and plan year each begin on January 1, 2012, and end on December 31, 2012. The sponsor incurs and deducts costs for 2012. In 2014, the sponsor undergoes reconciliation for RDS payments received for costs incurred in the 2012 plan year. Reconciliation shows that additional amounts of the sponsor's costs were qualified costs and the sponsor receives additional RDS payments. How do the additional RDS payments affect the amount allowable as a deduction for costs	**A4:** The additional RDS payments the plan sponsor receives through reconciliation in 2014 relate to costs the sponsor incurs in 2012. The deductibility of these costs is governed by the law in effect in 2012. Therefore, the sponsor may disregard the additional RDS payments it receives as a result of reconciliation in 2014 in determining the amount allowable as a deduction for costs incurred in 2012.	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy

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	incurred in 2012?				
Retiree Drug Subsidies	**Q5:** A plan sponsor's taxable year and plan year each begin on January 1, 2013, and end on December 31, 2013. The sponsor incurs and deducts costs for 2013. The sponsor calculates its costs with reasonable accuracy when preparing its taxable year 2013 income tax return. In 2015 the sponsor undergoes reconciliation for RDS payments for costs incurred in the 2013 plan year. Reconciliation shows that additional amounts of the sponsor's costs were qualified costs and the sponsor receives additional RDS payments. How do the additional RDS payments affect the amount allowable as a deduction for costs incurred in 2013?	**A5:** The additional RDS payments the plan sponsor receives through reconciliation in 2015 relate to costs the sponsor incurs in 2013. The deductibility of these costs is governed by the law in effect in 2013. As a result of the additional RDS payments after reconciliation, the sponsor may have deducted an excessive amount on its 2013 income tax return. Because the sponsor calculated its costs with reasonable accuracy on its 2013 income tax return, the sponsor reports the amount of the additional RDS payments as income on its 2015 income tax return to the extent required under the tax benefit rule.	FAQ Retiree Drug Subsidy	IRS	http://www.irs.gov/uac/Newsroom/Frequently-Asked-Questions:-Retiree-Drug-Subsidy
Retiree Drug Subsidies	**Q6:** The facts are the	**A6:** As a result of the plan sponsor's	FAQ Retiree	IRS	http://www.irs.gov/uac/Newsroom/Frequ

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	same as in Question 5, except that reconciliation determines that the plan sponsor received excess RDS payments and the sponsor repays the excess. How does returning the excess RDS payments affect the amount allowable as a deduction for costs incurred in 2013?	repayment of RDS payments after reconciliation, the sponsor may have deducted a lower amount of costs on its 2013 income tax return than was allowable. Because the plan sponsor calculated the amount of its deduction for the 2013 costs with reasonable accuracy, the sponsor deducts the additional amount it may have deducted for 2013 on its 2015 income tax return.	Drug Subsidy		ently-Asked-Questions:-Retiree-Drug-Subsidy
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q1:** Scenario - Husband H and wife W file taxes separately. They are BOTH looking for coverage on same application. Will they both have one SINGLE CSR or they could each potentially have different CSR?	**A1:** In this scenario, if H and W apply for coverage in the Marketplace and would like to be enrolled in the same plan, they would be assigned to the most generous plan variation for which all members in the enrollment group are collectively eligible. For example, if H is a member of a Federally recognized tribe and is eligible for a zero cost-sharing plan variation and F is eligible for a 73% silver plan variation, if they enroll in the same plan they would both be collectively eligible for the 73% silver plan variation. However, if they chose to enroll in separate plans, they would both be assigned to what they are both individually eligible for. Please see 155.305(g)(3) of the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule published March 11,	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf

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		2013. There will be one advance CSR payment amount for the entire enrollment group represented on the 834 at the subscriber level; there will be no individual level advance CSR payment amounts.			
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q2:** What does the CSR amount represent? Is that the amount CMS will pay each month for the family in CSR?	**A2:** The 834 from the Federally-facilitated Marketplace (FFM) to the QHP issuer will include the advance CSR payment amount that the issuer can expect to receive from CMS each month on behalf of the enrollment group. This is the advance CSR payment and does not represent actual CSRs paid on behalf of eligible enrollees throughout the benefit year. CMS will reconcile advance CSR payments made with actual CSRs during the CSR reconciliation process which will occur after the end of each benefit year. Please see §156.430 of the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule published March 11, 2013.	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q3:** If the family members do not all live in the same rating area, is the rate based off the subscriber's rating area?	**A3:** Yes, the rating area and resulting premium for the enrollment group is determined by the subscriber's rating area, not the dependents on a policy.	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf
Guidance on	**Q4:** Question: Slide	**A4:** The CSR AMT represents a dollar	FAQ February	CMS	https://www.regtap.info/uploads/library/

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Understanding the Rules of Enrollment Effective Dates	3 of the initial enrollment indicates a CSR AMT of 25.00. Can you confirm if this represents a dollar amount or percentage amount?	amount. This is the monthly advance CSR payment an issuer can expect to receive on behalf of the enrollment group.	27, 2013		ENR_WebinarQA-022713_5cr_060413.pdf
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q5:** What is the difference between PREAMT 9X on premium category and TOTRESAMT 9v on payment category?	**A5:** Please see the Enrollment Transaction Companion Guide (834 - Version 5010). PRE AMT 1 is a member level amount that will be utilized for all members in an enrollment group in an individually rated state. It is the individual rate submitted by QHP issuers during QHP certification for the member that will sum to the total premium determined by the Marketplace for the enrollment group. TOT RES AMT is the amount owed by the enrollment group toward the total premium. This is a subscriber level amount for the entire enrollment group.	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q6:** Will we receive APTC and CSR at the Member level or at Subscriber level? Also, how would the Marketplace address the scenario where a person changes	**A6:** The APTC and CSR payment amounts will be at the subscriber level for the enrollment group. In a situation where an individual elects to change their actual APTC during the year, the FFM will generate an 834 change transaction which will be sent to the issuer with the new information.	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf

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	his/her APTC election during the year?				
Guidance on Understanding the Rules of Enrollment Effective Dates	**Q7:** Will you be sending an enrollment transaction but no premium on FFM? What about premium tax subsidy?	**A7:** Please see the Enrollment Transaction Companion Guide 834 (version 5010). The FFM will send an enrollment transaction which will include the premium amount due for each enrollment group. The FFM will not be aggregating enrollee premium payments for issuers. CMS will send a monthly APTC payment for issuers for all confirmed enrollments that are APTC eligible and enrolled.	FAQ February 27, 2013	CMS	https://www.regtap.info/uploads/library/ENR_WebinarQA-022713_5cr_060413.pdf
Enrollment and Payment Processing Overview	**Q1:** How will issuers receive information on subsidy amounts and cost-sharing reduction (CSR) plan variations?	**A1:** The 834 will indicate the plan variation or standard plan in which the enrollment group should be enrolled. This will be indicated by the QHP ID, which will include a 14-digit standard component ID with a 2-digit variation component. With this QHP ID, the issuer will know which CSR plan variation or standard plan to enroll the enrollment group. The advance CSR payment amount that will be paid to the issuer on behalf of that enrollment group per month will be included in the 2750 loop. The monthly advance payment of the premium tax credit (APTC) amount for the enrollment group will also be captured in the 2750 loop.	FAQ January 30, 2013	CMS	https://www.regtap.info/uploads/library/ENR_Webinar_QA-013013_5cr_052913.pdf

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		The 2-digit Variation Component has the following values and description: The 2-digit Variation Component has the following values and description: 00 - Non-Exchange variation 01 - Exchange variation (standard plan – no CSR) 02 - Zero cost-sharing plan variation 03 - Limited cost-sharing plan variation 04 - 73% AV silver plan variation 05 - 87% AV silver plan variation 06 - 94% AV silver plan variation The assigned Qualified Health Plan Identifier is a concatenation of the 2. An example of both the Plan Id and Variant Component ID is as follows: 12345VA002002104			
Enrollment and Payment Processing Overview	**Q2:** Are CSRs available for the pediatric dental benefit?	**A2:** CSRs do not apply to stand-alone dental plans. If the pediatric dental benefit is offered by a QHP, then CSRs do apply. See §156.440(b) of the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule published March 11, 2013.	FAQ January 30, 2013	CMS	https://www.regtap.info/uploads/library/ENR_Webinar_QA-013013_5cr_052913.pdf
Enrollment and Payment Processing Overview	**Q3:** How will discrepancies between issuer records and CMS records for monthly payments for APTCs and CSRs be handled?	**A3:** A process will need to be established between CMS and issuers to work out any discrepancies in monthly advance payments made for APTC and CSR. The process is under development.	FAQ January 30, 2013	CMS	https://www.regtap.info/uploads/library/ENR_Webinar_QA-013013_5cr_052913.pdf

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Enrollment and Payment Processing Overview	**Q4:** Will APTC and CSR payments be at the subscriber or the individual level?	**A4:** The APTC payment amount and the CSR advance payment amount on the 834 will be at the subscriber level for the enrollment group.	FAQ January 30, 2013	CMS	https://www.regtap.info/uploads/library/ENR_Webinar_QA-013013_5cr_052913.pdf
Enrollment and Payment Processing Overview	**Q5:** Do catastrophic plans need to have CSR plan variations (including the limited and zero cost sharing plan variations for American Indians/Alaska Natives)?	**A5:** CSRs and APTCs do not apply to catastrophic plans. See §156.440(a) of the HHS Notice of Benefit and Payment Parameters for 2014; Final Rule.	FAQ January 30, 2013	CMS	https://www.regtap.info/uploads/library/ENR_Webinar_QA-013013_5cr_052913.pdf
Qualified Health Plan (QHP) Policy	**Q1:** When will the final FFE (SHOP) Group Enrollment layout be released? Could you provide a URL of where it will be posted?	**A1:** Further guidance on group enrollment will be released shortly.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf
Qualified Health Plan (QHP) Policy	**Q2:** Is the primary employer address rating requirement applicable to SHOP in a State-based Exchange as well as the FFE?	**A2:** Yes, the primary employer's address rating requirement will apply inside and outside of SHOPs and will apply to the FF-SHOP as well as State-based SHOPs.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf

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Qualified Health Plan (QHP) Rating Data	**Q3:** SHOP (ESI)Business Question: When calculating (building) rates for small employer coverage (ESI) policies do we build rates based on the employer address or the subscriber address?	**A3:** We intend to propose in future rule-making 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.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf
Qualified Health Plan (QHP) Rating Data	**Q4:** SHOP (ESI) Business Question: Will the FF-SHOP share dependent addresses? If dependent addresses are not provided, should an issuer default to the subscriber's address when calculating premiums?	**A4:** We intend to propose in future rule-making 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.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf
Qualified Health Plan (QHP) Rating Data	**Q5:** Off-exchange Small Employer Business Question: When calculating (building) rates for small employer coverage (ESI) policies, do we build rates based on the employer address or	**A5:** We intend to propose in future rule-making 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.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf

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	the subscriber address?				
Qualified Health Plan (QHP) Rating Data	**Q6:** Off-exchange Small Employer Business Question: If required to utilize the subscriber address when building premiums in the small group market – are we able to default to the subscriber's address for everyone on the policy OR are issuers required to base rates off of the dependent addresses as well?	**A6:** We intend to propose in future rule-making 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.	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf
Qualified Health Plan (QHP) Rating Data	**Q7:** How do we rate an employee who works out of state from home for an organization that is located in our state?	**A7:** We intend to propose in future rule-making 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. 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. However, if there is only one account, we intend to propose to use the employer's business location in the state where the account is established for	FAQ May 21, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_QHPSHOP_FAQs_052113__5CR_052413.pdf

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		geographic rating--regardless of other work locations.			
QHP Dental Frequently Asked Questions (FAQs)	**Q1:** Can an issuer be certified to offer stand-alone dental plans only off of the Exchange?	**A1:** If an issuer would like to offer a stand-alone dental plan only off of the Exchange in a state with a Federally-facilitated Exchange but receive Exchange certification that it meets standards related to the pediatric dental essential health benefits, then the issuer must select the "off Exchange" option in the dental-specific plan and benefits template. To be considered "Exchange-certified," the issuer of the stand-alone dental plan must complete the certification process up the point of signing the agreement. This process would provide a stand-alone dental plan with the "Exchange-certified" status outlined in the EHB final rule where a health insurance issuer could offer a health plan without the pediatric dental EHB to an individual if the issuer is reasonably assured that the individual has obtained pediatric dental EHB coverage through an Exchange-certified stand-alone dental plan.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf
QHP Dental Frequently Asked Questions (FAQs)	**Q2:** What parts of the Federally-facilitated Exchange certification application do stand-alone dental plan issuers complete?	**A2:** Issuers of stand-alone dental plans must complete all sections of the QHP application for stand-alone dental plans in the FFE, except for the pharmacy template, the accreditation template, and the unified rate review template. Issuers should use the dental plan and benefits	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		template 1.32 or later in order to activate the modifications that are specific to stand-alone dental plans. More information on what parts of the application apply to stand-alone dental plans can be found in three documents: 1) a chart titled "Application requirements related to stand-alone dental plans" posted on Regtap on April 18, 2013; 2) the presentation "Stand-alone Dental Plans Applying for Certification in the FFE" posted on 05/02/13; and, 3) Chapter 4 of the Letter to Issuers (http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf).			
QHP Dental Frequently Asked Questions (FAQs)	**Q3:** What benefits are required to be included in stand-alone dental plans?	**A3:** In order to be certified, all stand-alone dental plans must cover the pediatric dental essential health benefits, as required in the Affordable Care Act. As outlined in section 156.150 of the EHB final rule, a stand-alone dental plan must offer the pediatric dental EHB but may offer additional benefits, which could include non-pediatric coverage. We note that only the pediatric dental benefit, and not any non-pediatric coverage, would be subject to EHB standards, including complying with the requirement to offer benefits that are substantially equal to the benchmark and meeting AV and out-of-pocket limit requirements for stand-alone dental	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		plans. Stand-alone dental plans that are submitted without coverage of the pediatric dental EHB will not be certified. State-specific benchmarks for the pediatric dental benefit are listed in the EHB final rule. We note that a stand-alone dental plan could enroll adults only in a family plan. All of the templates for the certification application are the same for stand-alone dental plans as for QHPs, except for the modified plan and benefits template. These templates, including the dental plan and benefits template, are available on zONE and SERFF (http://www.serff.com/plan_management_data_templates.htm			
QHP Dental Frequently Asked Questions (FAQs)	**Q4:** How do rating tables and rating business rules apply to stand-alone dental plans?	**A4:** For the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must complete the rates table and associated business rules table according to the rating rules. Stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. The modified dental plan and benefits template will have a data field in which dental issuers will indicate whether they are committing to the rates in the template, and thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments. The plan display will indicate to consumers	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		whether the premium displayed for stand-alone dental plans is a guaranteed rate or an estimated rate. Please see pages 31-32 of the letter to issuers for additional information (http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf).			
QHP Dental Frequently Asked Questions (FAQs)	**Q5:** Do health plans outside of the Exchange need to cover the pediatric dental EHB? How would that work with stand-alone dental plans outside of the Exchange?	**A5:** The EHB final rule (78 FR 12834) stated the following with respect to coverage of pediatric dental EHB in the outside market: "The Affordable Care Act does not provide for the exclusion of a pediatric dental EHB outside of the Exchange as it does in section 1302(b)(4)(F) of the Affordable Care Act for QHPs. Therefore, individuals enrolling in health insurance coverage not offered on an Exchange must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan off the Exchange, that individual would already be covered by the same pediatric dental benefit that is a part of EHB. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified stand-alone dental plan offered outside an Exchange, the issuer would not be found noncompliant with EHB	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. HHS notes that the stand-alone dental plan would have to be an Exchange-certified stand-alone dental plan to ensure that it covered the pediatric dental EHB, as required for Exchange certification under section 1311(d)(2)(B)(ii) of the Affordable Care Act. However, the Exchange-certified stand-alone dental plan would not need to be purchased through an Exchange. This alternate method of compliance is at the option of the medical plan issuer, and would only apply with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand-alone dental plan."			
QHP Dental Frequently Asked Questions (FAQs)	**Q6:** What if a stand-alone dental plan does not contract with any of the essential community providers listed on the dental ECP list, or contracts with the dentists at those facilities directly but not with the facility itself?	**A6:** Only facilities should be listed on the ECP template, not individual providers. If an issuer of a stand-alone dental plan does not believe the ECP standard can be met due to the limited number of dental-specific ECP providers, then the issuer should submit a narrative justification using the ECP Supplemental Response Form to describe why the standard cannot be met and how the existing network would provide access for low-income and	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		medically underserved populations. If an issuer of a stand-alone dental plan contracts with ECP-like providers, but not the facilities listed on the list, then this should also be described in the ECP Supplemental Response Form. For the submission of the ECP template, please follow the instructions for entering "dummy data" on page 9 of the Chapter 7 Instructions for the Essential Community Providers Application section if you do not have any dental ECPs to submit. The Chapter 15 SADP Application Instructions also contains additional information.			
QHP Dental Frequently Asked Questions (FAQs)	**Q7:** If an issuer has not submitted a medical QHP application yet, can the issuer submit medical and stand-alone dental plan applications during the dental plan window?	**A7:** Applications for medical QHP were due to the FFM on May 3, 2013. The stand-alone dental submission window is available only for the submission of stand-alone dental plans. Issuers of QHPs who have already submitted QHP applications can use the stand-alone dental submission window to add information related to dental to their existing QHP applications where appropriate, but the addition of QHPs is not allowed. The document titled "Application requirements related to stand-alone dental plans" that was posted to Regtap on April 18, 2013 outlines how stand-alone dental plan information should be added to QHP applications that have already been submitted.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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QHP Dental Frequently Asked Questions (FAQs)	**Q8:** Because the windows overlap, what should issuers do if they are submitting changes for the Limited Correction Window but also want to add information to the existing QHP applications for stand-alone dental plans?	**A8:** Issuers that have received notification from CMS that they should make certain data corrections during the Limited Correction Window should make the changes and resubmit the complete QHP applications between May 20 – 22nd. After the QHP submissions are processed, the issuer should then proceed with the process of re-opening the applications to start adding information related to stand-alone dental plans. The application must then be resubmitted with all information for stand-alone dental plans by June 5th.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf
QHP Dental Frequently Asked Questions (FAQs)	**Q9:** What are the constraints on stand-alone dental plans when filling out the rating tables?	**A9:** The rating tables should be filled out according to federal requirements and any applicable state law. As described in the FAQ released on May 10, 2013, because dental is an excepted benefit, issuers then have the option to indicate whether the release is "guaranteed" or "estimated" in the plan and benefits template. Please see page 31 of the Letter to Issuers for more detail on the estimated/guaranteed rate distinction.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf
QHP Dental Frequently Asked Questions (FAQs)	**Q10:** Is the dental application window the same for issuers seeking certification	**A10:** All applications for certification of stand-alone dental plans in states with a Federally-facilitated Marketplace must be submitted between May 20 and June	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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	for off-Exchange stand-alone dental plan products only?	5, 2013.			
QHP Dental Frequently Asked Questions (FAQs)	**Q11:** Does a stand-alone dental plan have to use the Chapter 13m SADP Actuarial Value form?	**A11:** Issuers of stand-alone dental plans must provide documentation that the actuarial values submitted in the plan and benefits template were based on analyses conducted by a member of the American Academy of Actuaries and were performed in accordance with generally accepted actuarial principles and methodologies. The Chapter 13m contains the minimum information needed for certification and serves as a template for the actuarial value documentation, but issuers could provide alternate documentation that provides the same information.	FAQ May 31, 2013		
QHP Dental Frequently Asked Questions (FAQs)	**Q12:** To what extent should issuers of stand-alone dental plans enter information for adult dental benefits?	**A12:** For purposes of filling out the rating tables and plan and benefit template for off-Exchange plans, we recommend entering the rates and benefits as you intend to offer the plan, which could be as a child-only plan or as a family plan that includes adult coverage. The FFM will certify submitted plans based on whether they meet the minimum standards for certification for stand-alone dental plans, particularly the pediatric dental EHB. Because adult benefits are not considered EHB, there are no specific	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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		federal benefit and rate requirements. The amount of plan-level information included for such benefits is at the discretion of the issuer.			
QHP Dental Frequently Asked Questions (FAQs)	**Q13:** With respect to the Rates Template for QHP Application submission, how should stand-alone dental plans complete the tables for the pediatric under 19 rates? There appears to only be an option of 0-20 in the drop-down column for "Age".	**A13:** Stand-alone dental plans should enter their 0-18 rate in the 0-20 column of the rating tables. If the issuer chooses to indicate a guaranteed rate, the 0-18 rate will be the rate charged for 19 and 20-year olds as well. Note that the rates for 19 and 20 year olds can be averaged into the overall rate for that age band. In addition, there is no requirement to offer EHB coverage to individuals over 18 or the pediatric age set by your state, so while the rate will be encompassed in the age band the benefits can be different. Dental issuers may also identify the rates as 'estimated' and charge a different premium before the consumer effectuates enrollment. Please see page 31 of the Letter to Issuers for more detail on the estimated/guaranteed rate distinction.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf
QHP Dental Frequently Asked Questions (FAQs)	**Q14:** The dental benefits in the Plan & Benefits template seem very general compared to the benchmark plan. How do I indicate that I cover other	**A14:** The pediatric dental EHB is determined by the benchmark plan selected by the state, not by the categories of benefits in the Plan & Benefits template. For the purposes of meeting EHB requirements, pursuant to 45 CFR 156.115(a)(1), the plan must offer benefits and limits that are	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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	benefits or have more specific limits and do I need to enter these at a diagnostic code level?	substantially equal to the state's EHB benchmark plan. Although the categories of benefits may be broader than what is included in the benchmark plan, issuers should fill out the template in a manner that best represents the EHB covered by the plan. This does not need to be at a diagnostic code level. An issuer may add additional or more granular benefits and limits using the "Other" tab in the plan and benefits template.			
QHP Dental Frequently Asked Questions (FAQs)	**Q15:** What information needs to be provided for the EHB Apportionment field in the plan and benefits template for stand-alone dental plans?	**A15:** Issuers of stand-alone dental plans in the individual market should enter into the EHB Apportionment field the dollar amount that reflects the portion of the premium allocable to the pediatric dental essential health benefit. The dollar amount should reflect the statewide average amount for that plan. This number will be used to determine the amount of the advance payment of the premium tax credit under 45 CFR 155.340(e)(2). The issuer of the stand-alone dental plan also needs to submit the Chapter 13n Description of EHB Allocation form as a supporting document.	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf
QHP Dental Frequently Asked Questions (FAQs)	**Q16:** In the plan and benefits template, how should the maximums and deductibles be	**A16:** Issuers should enter maximums and deductibles in the plan and benefits template that are specific to the pediatric dental EHB. There are no regulatory requirements related to the non-EHB	FAQ May 31, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_DentalFAQsV2_5cr_060313.pdf

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	entered if they are different from adults and children as there is only one data field?	adult dental benefits, and therefore, the information necessary for certification that the stand-alone dental plan meets the pediatric dental EHB standards is the information specific to the pediatric dental benefit. For purposes of plan compare, consumers can access additional information about adult benefits through the link to the plan brochure.			
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q1:** Can you confirm that the consumer account is associated to the brokerage, not just the individual agent? This question comes from our need to continue servicing the consumer over time despite individual agents transitioning from the organization.	**Q2:**There will be two types of association: • With the brokerage; and • With the Individual Agent/Broker. The association with the brokerage will be used only for edits such as whether the consumer can submit a change through that brokerage. The association with the individual agent/broker would allow that agent/broker to access the consumer in future without answering the assister association questions. If a different agent/broker (whether from the same brokerage or not) were to assist the consumer, the system would require the agent/broker to provide responses (obtained from the consumer) to the assister association questions.	FAQ June 10, 2013		**NO LINK-INFO FROM WORD DOC. (1-17)**
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q2:** When a consumer requests enrollment into a plan sponsored by a	**A2:** The web-broker should redirect the consumer to the FFM.	FAQ June 10, 2013		

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	carrier that chooses not to contract with "web brokers", do you see the web broker referring the consumer to enroll directly on the FFM or should the web broker submit the enrollment using the normal process?				
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q3:** Support for other languages required? Which languages? What level of support e.g. is PDF summary sufficient or must we localize our entire UI?	**A3:** Yes. Under 45 C.F.R. 155.220(c)(3)(i), web-brokers are required to meet standards for disclosure and display of QHP information as described in 45 C.F.R. 155.205(c). This includes provision of language services at no cost to the individual. CMS expects web-brokers to offer the same level of language service as the FFM website, which will support key program topics in English and Spanish. For more information about the FFM website, please refer to chapter 6 of CMS's Letter to Issuers (available here: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q4:** Are all states on FFE supported in the same way? States that use FFE seem to	**A4:** Yes, to the extent that enrollment by web-brokers is permitted by a state, at this time we expect that web-broker enrollment in all FFE and state	FAQ June 10, 2013		

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	have different relationship types with FFE - for integration purposes are all States treated in the same way?	partnership exchange states would be supported using the same approach.			
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q5:** What are the Guidelines for displaying QHPs, APTC, CSR?	**A5:** Please see the agent/broker FAQ for more information about display of QHPs. We will also be issuing future guidance to web-brokers on display of APTCs and CSRs.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q6:** Will FFE proactively notify the WBE of changes in eligibility and enrollment?	**A6:** No. Notices will be sent directly to the consumer.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q7:** What criteria are used to determine eligibility to enroll in a QHP (not including subsidy eligibility)?	**A7:** Web-brokers will not need to determine eligibility for applicants. All eligibility determinations will be handled through the Exchange in accordance with 45 C.F.R 155.305.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q8:** What is the SLA for FFE WS?	**A8:** This information will be provided in future guidance.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q9:** If a user disassociates his account from the partner (WBE) account, will the partner be recognized as the Broker of Record when the Enrollment is sent to	**A9:** No, for both parts. The NPN included in the 834 will always be what is received as part of the "submit enrollment" transaction. Association with a brokerage or disassociation would have no impact on the NPN (or Broker of record) sent on the 834 (initial or changes)	FAQ June 10, 2013		

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	the Issuer? What happens if user disassociates his account AFTER the enrollment is sent to the Issuer?				
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q10:** For Interaction Scenario #6, does FFE include the URL of the Partner Web Site in the Notice to the User about Loss of APTC/CSR?	**A10:** There is no plan to include the partner's URL in the notice.			
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q11:** Who is our technical contact at the FFE? Can we send questions via email as they arise? Can we have regular meetings?	**A11:** Please continue to direct your questions to Pete Nakahata. We will be scheduling an upcoming technical working session.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q12:** "FFE will associate the Consumer's FFE account with the partner web site. Note 5: Consumer may choose to return to the FFE directly and perform their entire shopping on the FFE including Enrollment" Question: If a	**A12:** No, at this time the consumer will not be redirected back to the Partner website if the consumer quits the application before completing it.	FAQ June 10, 2013		

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	consumer quits the Application for Eligibility before completing it and later comes back to the FFE to complete the Application, will the consumer be redirected to the WBE/Partner site?				
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q13:** Does WBE/Partner web site need to meet some accessibility standards? If yes, what are they?	**A13:** Yes. Under 45 C.F.R. 155.205(c)(1), which applies to web-brokers, web-brokers must provide information in plain language and in a manner that is accessible and timely for individuals living with disabilities. As indicated in the regulation, this includes maintaining an accessible web site and providing auxiliary aids at no cost to the individual, in accordance with the ADA and section 504 of the Rehabilitation Act.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q14:** To be clear, FFM is not offering SSO via SAML 2 for WBE consumer to SSO into FFM. FFM is using SAML 2 to provide secure redirect and transfer between WBE to FFM. Is this correct?	**A14:** This is correct. FFM is not offering SSO via SAML2. Users have to login into FFM.	FAQ June 10, 2013		
Responses to Questions Submitted by Web-	**Q15:** During the Transfer process,	**A15:** The public key will be obtained during the onboarding process. This will	FAQ June 10, 2013		

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Brokers – June 10, 2013	using SAML 2 spec, we use digital signature for SAML assertion. We assume the public key comes from the certificate onboarding process outlined in DSH_INT_Requester Onboarding.docx. Is that correct?	be used for authenticating the entity during the secure transfer process to FFM. Additionally SAML2 spec does allow the public key to be included within the x.509 data element of the ds:signature. This will be used by digital signature validation. So we expect the x.509 cert to also come as part of SAML2 assertion.			
Responses to Questions Submitted by Web-Brokers – June 10, 2013	**Q16:** Does FFM view the SAML 2 secure transfer process as meeting NIST level 3? That it is multi-factor authentication based on: 1. Information Exchange System ID (something that you know). 2: x.509 certificate (something that you have). Or Does FFM view the SAML 2 secure transfer process as meeting NIST level 2? Is there specific CMS guidance on which NIST level needs to be met for secure transfer between	**A16:** There are 2 levels of authentication happening here. • Entity level authentication – This is done between the Issuers/Web-Brokers and the FFM application. The x.509 certificates are used for this. The DSH onboarding process takes care of validating the entity that provides the higher level of assurance. • User(broker) level authentication - The brokers requiring access to FFM have to register at CMS portal that requires LOA3. This is handled by the Remote ID proofing.	FAQ June 10, 2013		

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<tr><td></td><td>WBE and FFM?</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Responses to Questions Submitted by Web-Brokers – June 10, 2013</td><td>Q17: Do you have any information on which browsers will be supported for the subsidy application portion of the FFM?</td><td>A17:
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<tr><th>OS</th><th>Browser</th><th>Versions Supported</th><th>Current Version</th></tr>
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<tr><td>XP: IE7-8
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Win8: IE10</td><td>Internet Explorer</td><td>IE7, Ie8, Ie9, Ie10+</td><td>10</td></tr>
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<tr><td>XP or Win7</td><td>Opera</td><td>11.6, 12+</td><td>12</td></tr>
</table></td><td>FAQ June 10, 2013</td><td>CCIIO</td><td></td></tr>
<tr><td>Technical Guidance for SHOP</td><td>Q1: The enrollment scenarios shown during the webinar were dated the end of October 2012. Should we expect updated scenarios in the new version of the Enrollment Companion Guide?</td><td>A1: The set of scenarios, which describe the many enrollment variations for enrollees, such as initial enrollments, terminations, changes, and cancellations in the Federally-facilitated SHOP (FF-SHOP) are a development, training and testing tool. While the scenarios will not be included in the Enrollment Companion Guide, they are being updated, and will be made available in our issuer resource sites soon. These sites may include www.REGTAP.Info, the zONE or the CCIIO website.</td><td>FAQ June 20, 2013</td><td>CMS</td><td>https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf</td></tr>
<tr><td>Technical Guidance for SHOP</td><td>Q2: Do the enrollment scenarios</td><td>A2: No, the enrollment scenarios do not provide all the requirements for issuers</td><td>FAQ June 20, 2013</td><td>CMS</td><td>https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.p</td></tr>
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	provided include all requirements for the issuers in terms of handling enrollment? If not, can we get all of the requirements and edits from the Companion Guide?	to handle every enrollment situation. Furthermore, the purpose of the Companion Guide is to assist issuers to successfully send a compliant 834 enrollment transaction when used in conjunction with the ASC X12 834 Benefit Enrollment and Maintenance Transaction Implementation Guide/TR3 Version 5010. The Companion Guide provides specific rules for certain fields and data elements so that the 834 enrollment transaction can be used in the Marketplace, whether for individual or SHOP enrollment.			df
Technical Guidance for SHOP	**Q3:** We were informed that there was a new version of the FFM Enrollment Companion Guide. We had received previously (v1.0 with an issue date of 1/31/13). What is the most current version of the document and where can it be found?	**A3:** The current version of the Enrollment Transaction Companion Guide can be found on the CCIIO website at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf .	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Technical Guidance for SHOP	**Q4:** Will you be releasing a SHOP-specific 834 Companion Guide?	**A4:** No, the Enrollment Companion Guide includes individual and SHOP instructions	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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Billing Questions	**Q5:** Will the Marketplace set an invoicing date with which all issuers can synchronize?	**A5:** In 2014 the FF-SHOP will not establish a required date for issuers to invoice employer groups. Beginning with plan years on and after January 1, 2015, the FF-SHOP intends to invoice groups on the 10th of the month before a coverage month begins. In the first year of the program, the FF-SHOP will not establish a required date for issuers to invoice employer groups.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q6:** Will billing address and contact information for the employer be included in the group enrollment file?	**A6:** Yes, employer contact information, such as billing address, will be included in the group enrollment file from the FF-SHOP.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q7:** Some groups request that employees be split, for example by plant location, and bills be sent directly to the plant location for a subset of employees. What will be allowed in the FF-SHOP?	**A7:** Employers can enroll in 1 SHOP per State, and the ratings will be based on the location of a company's primary business address in a State, and only 1 mailing address will be collected and sent to issuers.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q8:** Will there be a version of the X12 820 transaction with premium information sent to issuers by the	**A8:** In the first year of the program (2014), there will not be any premium payment transaction reporting done with the FF-SHOP. However, when the premium aggregation program becomes	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	FF-SHOP?	available in the FF-SHOP, we anticipate using an X12 820 transaction to communicate information about premium payments.			
Billing Questions	**Q9:** Please explain the process to cancel groups that decide to terminate coverage prior to the enrollment effective date and before the end of the open enrollment period?	**A9:** If a group decides to cancel coverage prior to an effective date, the FF-SHOP will send an 834 enrollment transaction terminating coverage for the group and associated employees. Employers can make termination requests online at the FF-SHOP site or through the FF-SHOP call center.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q10:** Are issuers required to support online payments?	**A10:** In 2014 when issuers are billing employer groups and collecting premium payments, issuers are not required to support on-line payments, but they are permitted to offer the option of on-line, electronic payments. Employers will be redirected from the FF-SHOP website to the issuer's website to make the initial premium payment. If an issuer does not provide online (electronic) payment capability, the issuer should provide instructions for how the premium payment is to be made.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q11:** Are issuers required to cover groups for 30 days if no payment is	**A11:** An issuer will not be expected to cover a group for 30 days if an initial payment is not received by the coverage effective date.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	received from the group?				
Billing Questions	**Q12:** How long does an employer have to "make payment" prior to effectuation?	**A12:** Employers are expected to make their full monthly payment prior to the initial coverage effective date. After the initial enrollment, standard grace periods allowed by state regulation will apply.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Billing Questions	**Q13:** What is the SHOP payment grace period?	**A13:** In 2014, a FF-SHOP issuer is expected to comply with allowable state regulations pertaining to grace periods. In 2015 when multiple issuers will be available to a small businesses participating in the FF-SHOP and when the FF-SHOP will be billing and remitting payments received to issuers, there is a need to standardize grace periods across issuers based on allowable state regulations. The FF-SHOP is planning to have a 31 day grace period--unless a state's regulation requires a longer period.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q14:** In 45 CFR 156.270 of the Exchange Final Rule, it states that the QHP issuer is responsible for sending the enrollee a notice of termination of coverage that	**A14:** Yes, the FFM will identify the codes for termination reasons, and will include these in future versions of the Companion Guide. Please check the CCIIO website at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	includes the reason for termination at least 30 days prior to the last day of coverage. Within the 834 Enrollment Companion Guide, it does not specify the codes that the FFE will transmit in the 2000 Loop INS04. Will the FFE establish standard codes that will be transmitted for the termination reason? Will these codes be included in the next version of the companion guide?	for the most recent copy of the Companion Guide.			
SHOP Enrollment	**Q15:** Will the FF-SHOP send 834 enrollment transactions prior to the issuer effectuating the group?	**A15:** Yes, the FF-SHOP will send 834 enrollment transactions to the issuer prior to effectuation of groups in the FF-SHOP.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q16:** Will issuers be required to effectuate the group for year 1 and re-evaluate their enrollment for year	**A16:** The FF-SHOP makes all eligibility determinations and will pass this information on to participating QHP issuers. Similarly, annual renewals will be facilitated by the FF-SHOP.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	2?				
SHOP Enrollment	**Q17:** Will the marketplace enforce a minimum group size? For example, we cannot underwrite an Employer with less than 10 employees (by state statute) irrespective of the participation rate.	**A17:** Our final regulations do not give us authority to enforce a minimum group size. However, as established in the Final Payment Notice, we are enforcing a 70% default minimum participation rate for the FF-SHOP. See § 155.705(b)(10)(i).	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q18:** What is the expected turnaround time from submission of group information to the issuer to group enrollment?	**A18:** Group information will be submitted to the issuer two weeks before the effective date of coverage for the FF-SHOP.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q19:** We assume now that issuers are responsible for billing and they will also be responsible for administering delinquency notices per existing state guidelines and will only notify the FFM of terminations for non-payment of	**A19:** As finalized in the SHOP Rule published on June 4, 2013, these assumptions are correct.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	premium. Please confirm or correct.				
SHOP Enrollment	**Q20:** Please explain how the group renewal process will work.	**A20:** 90 days prior to the end of a plan year, the FF-SHOP will send out a notice to employers to renew coverage and obtain employee commitments for the next 12 months. Employers will have 30 days to make election decisions and employees will have 30 days to elect coverage and choose a QHP (including the choice to remain with the same QHP).	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q21:** Is there a separate 834 enrollment transaction for each Employer?	**A21:** Yes, there is a separate group enrollment transaction per employer.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q22:** In the group file request and response, the plan max occurrence is "N". Are we getting multiple QHPs in one file or one QHP in one request?	**A22:** The group enrollment file is employer and issuer specific and supports multiple plans from a single issuer. As finalized in the SHOP Rule published on June 4, 2013, for coverage beginning before January 1, 2015, issuers will receive only one QHP per group file.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q23:** When we send an 834 enrollment transaction to cancel coverage due to non-payment, do we send	**A23:** Cancellations for non-payment affect the entire enrollment group, or all of the individuals covered through, and paid for by the same subscriber. The members were likely enrolled as an	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	a cancellation for each member?	enrollment group within a transaction. Therefore, the issuer will send a cancellation transaction of that enrollment group, in one transaction.			
SHOP Enrollment	**Q24:** If the QHP selected does not include pediatric dental, would a qualified dental plan be selected as well?	**A24:** Employers will be able to select and offer employees and their dependents a stand-alone dental plan through the FF-SHOP. If a QHP selected by an employer does not include pediatric dental, the employer will be notified they are not offering pediatric dental and be given the opportunity to choose a QHP with pediatric dental or offer a stand-alone dental plan.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q25:** If a subscriber already has insurance as a dependent, are they still eligible to obtain additional insurance via the FF-SHOP?	**A25:** Yes, if an individual has insurance as a dependent, but is also eligible to obtain insurance through the SHOP, s/he may obtain additional insurance through the FF-SHOP. In this scenario, insurance industry coordination of benefits rules in a State would apply.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q26:** If a QHP is added to a group in a subsequent group enrollment file, do you expect the original issuer group ID or a new one?	**A26:** For the FF-SHOP, the decision to use original issuer identifiers or new identifiers in future group enrollment files is based on the issuer's preferences for maintaining continuity and tracking purposes. Any new numbers will need to be cross walked to the original number for reporting purposes, so issuers will need to be prepared to report	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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		on original identifiers as well as new ones, and to be able to link those numbers for purposes of reporting and tracking.			
SHOP Enrollment	**Q27:** How will we be notified of group size and employee status (retired, etc.) to effectively process Medicare?	**A27:** We expect to provide information about group size and employee status in the group enrollment file and 834 enrollment file transfers.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q28:** Issuers need more clarification about the group information being sent using 834 (since 834s are for membership, not group). Is there a companion guide or something that defines what segments/loops are going to be used to communicate group data?	**A28:** CMS has provided information about the enrollment transaction, its contents, format and data elements through a variety of webinars and issuer calls. An updated version of the Group Enrollment File is being prepared and will be sent to issuers by late June or early July.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q29:** Will there be additional information available regarding ongoing group enrollment maintenance during	**A29:** Information included in the initial group enrollment may be updated during the year. Changes to enrollment and other member-level changes will be handled through the 834 enrollment transaction.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	the plan year? Specifically, how will changes to enrollment (new hires/terminations, etc.) be handled?				
SHOP Enrollment	**Q30:** Does an issuer ever receive a copy of the group application submitted to the FF-SHOP?	**A30:** Group enrollment information will be sent to the issuer prior to the coverage effective date, but the issuer does not receive a copy of an employer's group application.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q31:** How will an Issuer know how many people are enrolled in a group? We need this information in order to determine whether or not a small group has paid in full.	**A31:** Premium information for each employee associated with a group will be sent to issuers on a regular basis via 834 enrollment transactions.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q32:** Has there been a decision regarding how COBRA will be administered? When will a group need to submit payment for COBRA enrollees?	**A32:** Employees eligible for COBRA may enroll at the time of initial enrollment and throughout the year for groups participating in the FF-SHOP. Full payment is expected for the entire group, including COBRA payments, at the time of initial enrollment and before the end of applicable grace periods each month.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
SHOP Enrollment	**Q33:** For the	**A33:** CMS recently awarded the	FAQ June 20,	CMS	https://www.regtap.info/uploads/library/

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	reconciliation of the premiums in the 834 enrollment transaction and the payments by the groups, how does CMS expect issuers to communicate this information back to the FFM? Is there a specific format?	contract for the reconciliation scope of work. Details regarding the reporting, communication between issuers and CMS, discrepancy reports, report formats and many other details are under development. As details become available, they will be shared with issuers through regular channels.	2013		SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q34:** How will the SHOP know if a Broker is appointed?	**A34:** The FF-SHOP will pass broker identifying information to issuers on the group enrollment file. Issuers are expected to confirm appointments before paying commissions.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q35:** Will the TIN Identification number be used as the Broker ID or will it be the Contact ID?	**A35:** At minimum, the FF-SHOP will capture a broker's name and National Producer Number and transmit this identifying information to issuers on the group enrollment file.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q36:** Assuming a broker does not have a Tax ID Number (TIN), would you be sending a Social Security Number (SSN) in an application?	**A36:** Consistent with the model SHOP employer application (OMB Control No. 0938-1193), the FF-SHOP will pass a TIN number if one is entered by the broker, and will pass a SSN if that is what the broker enters into this field instead.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q37:** Please clarify	**A37:** Issuers will be sent a broker's	FAQ June 20,	CMS	https://www.regtap.info/uploads/library/

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	what broker (and Agency) information will be included in files sent to the issuer. In order to efficiently process commissions, it is very important to have, at least, broker SSN, broker name, and Agency (Payee) TIN.	name, National Producer Number, SSN or TIN, and contact Information when these are provided on an employer's FF-SHOP application.	2013		SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q38:** Will issuers receive a sample 834 file? And when will they be available?	**A38:** Yes, sample 834 files will be made available through the testing and EDI work groups. For details about these groups and to participate in testing, contact the Help Desk at cms_feps@cms.hhs.gov	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q39:** How is the exchange going to validate that all eligible employees have been offered coverage and are participating in SHOP?	**A39:** The FF-SHOP is considering conducting audits to validate information on employer and employee applications.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Broker Questions	**Q40:** Can you clarify what an "issuer group" is with	**A40:** Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf

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	regards to having to apply for certification in the SHOP?	of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.			
Administrative Questions	**Q41:** How can issuers get a copy of the SHOP presentation materials or other CCIIO presentations?	**A41:** Presentations from the CCIIO webinars are available in the resource section of the REGTAP website – www.REGTAP.info	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
Administrative Questions	**Q42:** Where can issuers obtain SHOP enrollment scenarios?	**A42:** The enrollment scenarios, which describe different enrollment related situations for enrollees, including initial enrollment, terminations, changes and cancellations in the FF-SHOP, are being updated. These will be made available on various issuer resource site channels when the revisions are complete.	FAQ June 20, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ_20130619_5CR_062013.pdf
HHS-Operated Data Collection Policy	**Q1:** Will HHS accept supplemental diagnosis codes for consideration in calculating enrollee risk scores when HHS operates risk adjustment on behalf of a State? What sources are permitted	**A1:** In the HHS Notice of Benefit and Payment Parameters for 2014, Final Rule, HHS indicated that standards related to use of chart review for data collection would be provided in future guidance. This FAQ is the initial guidance that HHS is providing on the subject of chart review as a source of supplemental diagnosis codes for acceptable claims and encounter data as	**TITLE?**	CMS	https://www.regtap.info/uploads/library/HHS_OperatedDataCollectionPolicyFAQs_062613_5CR_062613.pdf

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	for supplemental diagnosis codes; and, what are the data collection procedures for diagnosis codes from a supplemental source?	defined under 45 CFR § 153.710. Additional, detailed operational guidance related to collection of supplemental diagnosis codes will be provided in future guidance and in advance of the final data submission deadline of April 30, 2015. Guidance on Supplemental Diagnosis Codes for HHS-Operated Risk Adjustment: 1. HHS will accept supplemental diagnosis codes from the following sources: a. Fee-For-Service Claims Environment: i. Chart (medical record) review by the issuer subsequent to medical billing when an issuer has submitted risk adjustment data related to an allowed claim for hospital inpatient, hospital outpatient and professional medical services. In this case, the issuer has paid a claim that is the result of services provided to an enrollee and is supported by medical record documentation. In such cases, the chart review must evaluate all diagnoses on the original claim, and the issuer must delete any diagnoses not supported by the chart. We note that any chart review would be governed by applicable privacy and security laws and standards. Any diagnoses added through such a process would be linked to an individual's de-identified record on the			

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		issuer's edge server; HHS will not access individual records except in cases of audit. ii. Diagnosis codes that are received via electronic data interchange (EDI) and exceed the number of diagnosis codes that are accepted by the issuer's claims system. HHS understands that in some instances the number of an enrollee's diagnosis codes exceeds the number of diagnosis codes that the issuer's translator and claims system can accept. Issuers are allowed to pick up diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end. b. Encounters in a Capitated Environment: i. Chart (medical record) review by the issuer subsequent to medical billing when an issuer has submitted risk adjustment data related to an allowed claim for hospital inpatient, hospital outpatient and professional medical services. In this case, the issuer has paid a claim that is the result of services provided to an enrollee and is supported by medical record documentation. In such cases, the chart review must evaluate all diagnoses on the original claim, and the issuer must delete any diagnoses not supported by the chart. We note that any chart review would be governed by applicable			

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		privacy and security laws and standards. Any diagnoses added through such a process would be linked to an individual's de-identified record on the issuer's edge server; HHS will not access individual records except in cases of audit. ii. Routine medical record (chart) review. Supplemental diagnosis codes must be related to services that are defined as an encounter for hospital inpatient, hospital outpatient and professional medical services. iii. Diagnosis codes from allowed encounters. iv. Diagnosis codes that are received via electronic data interchange (EDI) and exceed the number of diagnosis codes that are accepted by the issuer's encounter system. HHS understands that in some instances the number of an enrollee's diagnosis codes exceeds the number of diagnosis codes that the issuer's translator and claims system can accept. Issuers are allowed to pick up diagnoses that were on the submitted claim transaction but truncated in the translator/EDI front-end process. 2. Issuer shall submit supplemental diagnosis codes to the distributed data environment (Edge Server) during the			

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		appropriate data collection period in a format designated by HHS (45 CFR § 153.700). **NOTE:** Because HHS is allowing supplemental diagnosis codes, an additional file format will be established to support this submission. HHS intends to provide information in future guidance for this additional format. The file format for collection of supplemental diagnosis codes shall require the identification of the source of the diagnosis codes. Specifically, a qualifier for source type will be a required data element. 3. Deletions of incorrect diagnoses shall also be submitted. If an allowable source of supplemental diagnosis codes (see item 1 above) identifies incorrect diagnosis codes, then an issuer shall submit a deletion in the additional file format (described in item 2). 4. Denied claims are not a source of supplemental diagnoses.			
Guidance on Supplemental Diagnosis Codes for HHS-Operated Risk Adjustment	**Q2:** Does HHS plan to utilize health assessments as a source of risk adjustment diagnosis codes?	**A2:** For the first year of operations, HHS will allow health assessment diagnoses to be submitted for the HHS-operated risk adjustment program provided that the diagnoses submitted based on these assessments comply with clinical coding guidelines. We would	**TITLE?**	CMS	https://www.regtap.info/uploads/library/HHS_OperatedDataCollectionPolicyFAQs_062613_5CR_062613.pdf

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		like to discuss this issue with the issuer community and determine the best approach to use in future years. We note that any diagnoses added through such a process would be linked to an individual's de-identified record on the issuer's edge server; HHS will not access individual records except in cases of audit.			
APTC and CSR Monthly Payment	**Q1:** The IRS administers the premium tax credit program. In the Notice of Benefit and Payment Parameters for 2014, HHS sets forth that issuers will receive advance payment of the premium tax credit (APTC) on a monthly basis. Which agency will make the APTC payments?	**A1:** The IRS and CMS established a payment process to begin in January 2014. Payments will be processed using existing federal payment systems through the Department of the Treasury. CMS will reach out to Federally-facilitated and State Based Marketplace issuers to provide additional information and receive financial account information starting in late summer 2013.	FAQ June 28, 2013	CMS	https://www.regtap.info/uploads/library/PYMT_FAQ1_5CR_062813.pdf
QHP Certification/Review Process	**Q1**: Is "Justification 13g: Cost Sharing for plans exceeding annual limitation on small group deductibles" required during the application, or during	**A1:** To the extent that the submitted plan deductibles exceed the statutory deductible limitations, the applicant should have submitted justification 13g along with its application. However, this form can be submitted during the resubmission window in response to communicated deficiencies. Through	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	deficiency phase?	submission of this form, the applicant attests that the identified health plans that are listed on the form exceed the annual limitation on small group deductibles and are doing so because they could not "reasonably reach a given level of coverage (i.e. metal level) without doing so." The applicant should also include discussion of why they could not reach the coverage levels. HHS would also recommend the issuer reach out to their state regulators as to their requirements in this area, as some states will be conducting the review of this information.			
QHP Certification/Review Process	**Q2:** Does each benefits template submitted require both a gold and silver plan? If an issuer is offering product off exchange only, are they required to offer a silver and gold plan?	**A2:** Under § 156.200(c)(1), a QHP issuer must offer through the Exchange at least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act. However, there is no federal requirement to offer gold or silver plans off the Exchanges. For additional information on how to access the Plans and Benefits Template that can account this, please refer to the May 22 announcement entitled "Guidance for QHP Issuers Submitting Non-Exchange Plans and/or Dental Rates" that is posted in REGTAP portal.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
QHP Certification/Review Process	**Q3:** Is there a limit on the number of plans an issuer can	**A3:** Not specifically, but issuers must ensure that their plan designs are meaningfully different.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	offer in the Exchange?				
QHP Certification/Review Process	**Q4:** Where are the specific attestations asking about network adequacy?	**A4:** The attestations relating to network adequacy are listed in QHP Instructions: Chapter 06 Network Adequacy Instructions which can be found on the www.REGTAP.info Website.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
QHP Certification/Review Process	**Q5:** How are the new data traceability matrices (DTMs) used in completing the templates?	**A5:** These files, available on CMS zONE describe the data elements in the templates and the high-level business rules and validation requirements for each element.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
QHP Certification/Review Process	**Q6:** Does an issuer have to be an approved Federal contractor in order to sign an agreement to market and sell on the Federally-Facilitated Marketplace (FFM)?	**A6:** No, the issuer does not need to be an approved Federal contractor.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
QHP Certification/Review Process	**Q7:** For the network URL, are there requirements for the number of clicks it will take to view the network providers?	**A7:** There is no requirement; however, we do advise issuers to ensure that network information is easily accessible to consumers.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
QHP Certification/Review Process	**Q8:** What will be the time window and process for the plans	**A8:** Issuers may update the links to their Plan Brochures and SBCs during either the resubmission process or the Plan	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	to update the links to their plan brochures and SBC's prior to October 1, 2013 Exchange go-live?	Preview process.			
QHP Certification/Review Process	**Q9:** For enrollees who are also Medicare beneficiaries, may a plan charge different premiums for enrollees based on whether their Medicare coverage is primary vs. secondary?	**A9:** No, as described at http://cciio.cms.gov/resources/factsheets/marketreforms-2-22-2013.html: Health insurance issuers may vary premiums only based on age (within a 3:1 ratio for adults), tobacco use (within a 1.5:1 ratio for adults and subject to wellness program requirements in the small group market), family size, and geography. Since factors related to Medicare and the coordination of Medicare benefits are not amongst the allowable rating factors, then plans may not charge the enrollees different premiums based on these factors.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Essential Health Benefits	**Q10:** If a state enacts a new requirement that issuers who provide coverage of IV chemotherapy must cover oral chemotherapy at parity, does the state have to defray the cost?	A10: 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 EHB Final Rule (45 CFR 156.122) we stated that plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Essential Health Benefits	**Q11:** If a state enacts	**A11:** *Defining* habilitative services	FAQ #2 June	CMS	https://www.regtap.info/uploads/library/

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	a new requirement for Applied Behavioral Therapy, is that a benefit above EHB or can Applied Behavioral Therapy be considered EHB because it is a service specific to an EHB category (falls w/in habilitative OR mental health including behavioral health treatment).	would not result in a mandate, but *requiring* specific treatments/benefits, including ABA, creates a new mandate. 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 – Bill requires private insurance companies to provide coverage under group health insurance policies for psychiatric care, psychological care, habilitative or rehabilitative care (including applied behavior analysis (ABA) therapy), therapeutic and pharmacy care to children who have been diagnosed with autism spectrum disorder (ASD).	28, 2013		PM_QHP_FAQ12_062813_5CR_062813.pdf
Actuarial Value	**Q12:** Can states require issuers to exclude non-preferred drugs as being non-EHB and, as a result, exclude this tier of drugs from a plan's actuarial value calculation?	**A12:** No. States may not require plans to exclude non-preferred drugs from EHB and, thereby, exclude these drugs from calculating a plan's actuarial value. EHB policy does not prohibit tiering unless such tiers are designed in a discriminatory manner. As stated in the preamble of the Final Essential Health Benefits Rule (78 FR 12848), while plans must offer at least the	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		greater of one drug in each USP category and class or the number of drugs (in each USP category and class) as in the EHB benchmark plan, plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding EHB. In other words, all drugs offered by the plan are considered essential health benefits. Therefore plans must take all drugs into account when calculating actuarial value. Plans that cover non-preferred drugs should mark that category as "covered" on the plans and benefits template and use the EHB Variance reason "additional EHB."			
Actuarial Value	**Q13:** Will a catastrophic plan have a lower AV than a bronze plan (i.e., below 58% AV)?	**A13:** No, a catastrophic plan does not have an AV. Information on how to input these plans into the Plans and Benefits Template is available the Chapter 10 instructions under "Catastrophic Plan Instructions."	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Actuarial Value	**Q14:** If a Bronze or Silver or possibly Gold plan has a deductible in excess of $2,000 (i.e., in excess of the limits set forth in Section 1302(c)(2)) of the Affordable Care Act, what does that do to its status as a QHP?	**A14:** Section 1302(c)(2) of the Affordable Care Act only applies to the small group market. As a result, the AV Calculator can exceed a $2,000 deductible to allow the calculator to account for situations where the user is running plan designs that are not small group plans.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Dental	**Q15:** Within the	**A15:** Yes, for purposes of QHP	FAQ #2 June	CMS	https://www.regtap.info/uploads/library/

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	Exchange, is it considered two plans if we offer a plan with and without embedded dental?	certification these would be considered two plans.	28, 2013		PM_QHP_FAQ12_062813_5CR_062813.pdf
Dental	**Q16**: How will plans with an embedded pediatric dental EHB apply for certification in the FFE?	**A16:** If pediatric dental benefits are embedded in the QHP, then the pediatric dental EHB would be treated like any other benefit for the purposes of premiums, AV, and out-of-pocket maximums for purposes of the FFE certification application. The pediatric dental EHB is considered embedded if the medical plan is also collecting the premium for the dental benefits, includes the dental benefits as part of its contract, and is legally liable for the claims experience of the dental coverage. This can be achieved through a subcontractual agreement; the key feature is the party that is legally responsible for the claims.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Dental	**Q17:** As URAC and NCQA accreditation does not apply to stand-alone dental plans, can a stand-alone dental issuer offering no QHPs answer "No" to accreditation questions and not be subject to	**A17:** The QHP certification requirement to have URAC or NCQA accreditation does not apply to stand-alone dental plans, so an Issuer offering only dental plans should answer “No” to the accreditation questions. This will not be considered a deficiency in the application. Outside of the Exchange, any applicable state laws regarding accreditation would apply.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	certification denial?				
Dental	**Q18:** If an issuer offers a stand-alone dental plan, can it set up the business rule or eligibility rules to ensure that only consumers that have selected the issuer's medical policy can purchase the dental plan?	**A18:** In the FFE, an issuer will not be able to tie enrollment between a QHP and a stand-alone dental plan.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Dental	**Q19:** Does the FF-SHOP participation provision at 45 C.F.R. § 156.200(g) apply to stand-alone dental issuers wanting to participate in the individual market FFEs?	**A19:** No. For the following reasons, we do not interpret the FF-SHOP participation provision as applying to stand-alone dental plans seeking certification to participate in the FF-SHOPs. First, the FF-SHOP participation provision provides that issuers are subject to it based on small group market share, which is determined based on earned premium data submitted annually to HHS by medical plan issuers pursuant to 45 C.F.R. § 158.110. Stand-alone dental issuers are not subject to the reporting requirement at § 158.110, and therefore HHS would generally not have the data it would require to determine whether they are subject to the participation provision. Second, the FF-SHOP	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		participation provision requires issuers subject to it to offer both a silver QHP and a gold QHP in the FF-SHOP. The terms "silver" and "gold" refer to comprehensive medical plans subject to the metal tier actuarial value requirements. Generally speaking, issuers of stand-alone dental plans, which are subject to different actuarial value level requirements and are permitted to issue stand-alone dental plans at only one level, would not be able to meet this requirement. We note that 45 C.F.R. § 155.1065(a)(3) requires stand-alone dental plans being offered through an Exchange to meet all qualified health plan (QHP) certification standards, except for any certification requirement that cannot be met by a stand-alone dental plan. We believe that the exception at § 155.1065(a)(3) applies to the FF-SHOP participation provision.			
Pharmacy	**Q20:** In question 42 of the 5/9/13 FAQ document previously posted to REGTAP, you stated that if a pharmacy claim cannot be pended during months two and three of the grace period, an issuer may deny the claim. This FAQ further	**A20:** Yes, where the issuer reimburses for a service to make the enrollee whole, the issuer should count applicable cost sharing towards to the MOOP.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	indicated that if the enrollee pays for prescriptions out-of-pocket and subsequently becomes up-to-date on premiums within the grace period, the issuer must reimburse its share of the cost of covered pharmacy benefits filled during the grace period, if the enrollee submits a receipt. In this case, can the issuer have reasonable procedures to count only the cost-sharing amount towards the out-of-pocket maximum (MOOP)?				
Rating	**Q21:** Where and when will information about tobacco use be collected from applicants?	A21: Consumers will answer a question regarding tobacco use as part of the plan selection process.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q22:** If a QHP is approved in a particular rating area to be sold on-Exchange, is that	**A22:** If a proposed plan is approved for sale in a rating area, it can be considered a QHP for the rating area for which it is approved.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	plan considered a QHP in all rating areas, even if it is not sold on the Exchange in those other rating areas?				
Rating	**Q23:** Does one set of rates apply for the entire calendar year, or can an issuer provide rates that change by month or quarter due to trend assumption changes?	**A23:** In the individual market, one set of rates applies for the entire calendar year. A rate is good until the end of a calendar year, so someone enrolling in June would have that rate until December 31 of that year. In SHOP, once a group has effectuated coverage, the rate is locked in for 12 months. If an issuer submitted trend increases during the initial QHP application window, approved rates will be applied as scheduled.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q24:** Will issuers have an opportunity to adjust rates throughout the year?	**A24:** For individuals, the rates are set on a yearly basis. We intend to provide further guidance on rate updates for the SHOP at a future time. In the Program Implementation NPRM under §156.80, we propose that issuers in the small group market (including SHOP) may make rate changes no more frequently than quarterly, effective as early as July 1, 2014. These rates would apply to both new and renewing businesses during the course of the year.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q25:** How do issuers indicate the rate trends for Small Group in the	**A25:** In order to indicate rate trends for Small Group, issuers can create four sheets on the template, with the appropriate (and non-overlapping)		CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	templates?	effective and end dates on the appropriate tab.			
Rating	**Q26:** What does "No Preference" mean in the tobacco use drop-down list?	**A26:** No preference means that there is only one rate, regardless of smoking status. If an issuer selects the other option (Smoking/Non-smoking), another column will appear, allowing the issuer to enter both smoking and non-smoking rates.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q27:** Will there be a field for a dependent child rate separate from ages 0-20?	**A27**: No, that is not available.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q28:** How can an issuer offer a plan and rates for only a portion of a rating area?	**A28:** Issuers should submit their service area using the Service Area template. The FFE does not require that an issuer's service area cover a complete rating area. However, issuers are also bound by State service area requirements, so issuers should carefully review their States' guidance on this topic to ensure that their proposed service areas comply with State requirements. In some states, issuers may be allowed to split service areas by submitting multiple applications.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q29:** Why are rates being requested by tier when the rates have to be built up by member?	**A29:** Rates, for the majority of States (except only New York at this point) are to be entered by age and tobacco status. These rates will then be used to build rates for individuals and families in the Exchange as their family demographics	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		are determined.			
Rating	**Q30:** What correlation is there, if any, between the Rating Areas and the Service Areas created in the Service Area template?	**A30:** The Service Area template defines the area (State-wide, a list of counties, or in rare cases partial counties) where a plan will be offered. In the FFE, a service area can cover one or more complete or partial rating areas. For each plan, issuers must submit rates for every rating area within its service area, and those rates will be displayed to the appropriate consumers within the plan's service area on Plan Compare. Issuers should also refer to any additional State requirements on Service Area and ensure that the proposed Service Area is in compliance.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q31:** The age column uses the term "subscriber" in the definition but the rate will be built by adding each individual member's rate together, correct?	**A31:** That is correct. In individually rated States, the rate will be determined by adding up the age-determined rates of all the individual members.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q32:** Does the rating template allow a tobacco rate for 18-20 year olds as well as 0 to 17 year olds?	**A32:** No. Individuals 20 years and under should be subject to the same rating rules.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q33:** For a family of	**A33:** The three-child cap refers to child	FAQ #2 June	CMS	https://www.regtap.info/uploads/library/

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	5, with 19-year-old parents, how would the three child cap apply?	dependents. In the case of two 19-year-old parents with three children, the parents would be rated as the primary and secondary subscriber, and all three children would be rated.	28, 2013		PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q34:** In the question "Is there a maximum age for a dependent?" on the Business Rules template, should this be interpreted as up to and including the age?	**A34:** This field is inclusive, so it should be considered up to and including that age.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q35**: How can issuers find the rating area IDs assigned for their State?	**A35:** This information is available at http://cciio.cms.gov/programs/marketreforms/state-gra.html.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q36:** In column L of the Business Rules template, why is it significant that the individuals on the policy live together?	**A36:** This field is provided because some issuers may allow certain dependent relationships when the dependent lives in the same household as the subscriber, but not if the dependent lives elsewhere.	FAQ #2 June 28, 2013	CMS	ttps://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q37:** Will there be only one area rating applied per application?	**A37:** Correct. This is necessary for both the federal rating engine and risk adjustment systems and processes.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating	**Q38:** Are child-only policies being sold strictly on a one per child basis? Will issuers be allowed to sell child-only with	**A38:** The market rules do not specify that child only policies should be issued with a certain number of children covered. The Exchange tools are built to support the inclusion of any number of children, with a maximum of three	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	the three child limit?	children being quoted on a policy. There is no way to identify a specific number of children who may be included. If an issuer desires to limit child-only policies to a single child, it may do so by indicating that it does not cover any of the allowed relationships to the reference person on the policy (rating rules template, right most column). If a plan is reported as not allowing siblings or other relationships, a child-only request would assign the reference to the youngest person under that request, and if no allowed relationship is identified, the other individuals on the request would be communicated back to enrollment as needing separate policies, which would be rated independently of the first policy. The exception to this is if one of the additional children is a spouse or domestic partner of the reference person, in which case that person would be allowed on the original policy as consistent with laws and the business rules evaluations.			
Rate Review	**Q39:** In order to enter plans on a combined basis, does each plan need to have the same exact rate increase**?**	**A39:** Plan rate increases can be entered as combined for the product or individually.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rate Review	**Q40:** Is the uniform	**A40:** All plans are required to be	FAQ #2 June	CMS	https://www.regtap.info/uploads/library/

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	rate review template required only for rate increases on existing products, not new rates?	included when the template is submitted, including new plans.	28, 2013		PM_QHP_FAQ12_062813_5CR_062813.pdf
Rate Review	**Q41:** Since issuers can vary distribution costs and administrative expenses by product, can an issuer offer all products with different distribution costs to a subset of the single risk pool groups?	**A41:** Division of risk pool groups is not permitted. All plans are guaranteed available and should be priced based on the anticipated populations the issue has, as a whole. For an issuer to do otherwise could mean that the issuer is segregating the risk pool and thus discriminating.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Essential Community Providers	**Q42: Should the non-exhaustive database listing for a particular service area be used to calculate a plan's ECP compliance with the Safe Harbor standard and/or Minimum Expectation?**	**A42:** The evaluation of an issuer's compliance with the safe harbor or minimum expectation standards as articulated in the Letter to Issuers on Federally-facilitated and State Partnership Exchanges in Chapter 1, Section 1 will consider the extent to which each network includes a sufficient number of ECPs that meet the regulatory standard for each service area the QHP will cover. HHS will use the non-exhaustive database of ECPs as the basis for determining the number of available ECPs in the QHP's service area. This would form the denominator of the percentage of available ECPs	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		included in the issuer's provider networks(s). All providers included in a QHP issuer's application that meet the federal regulatory standard will count toward the numerator of the evaluation percentage. The Letter is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf			
States	**Q43: Does the QHP Application impact state rate and form filing requirements? Will states use the QHP application in lieu of their form and rate filings?**	A43: States will continue to establish standards for rate and form filings, including what information and data issuers should provide, how issuers should submit such data, and when issuers should submit such data. Issuers should contact the appropriate state regulator(s) for assistance in complying with state requirements. Issuers should not assume that completion of the QHP Application will satisfy state rate and form filing requirements.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
States	**Q44:** How do issuers know which components the state will review vs. which components will be reviewed by the FFM?	**A44:** Where a FFM is operating, CMS will conduct QHP certification. However, as CMS indicated in the "Guidance on State Partnership Exchanges" (available at: http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/partnership-guidance-01-03-2013.pdf), CMS recognizes that determination of whether issuers and health plans meet QHP certification standards outlined in 45 CFR 156.200	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		involves activities that are already or will be performed by state regulators under state law, including state laws that address 2014 market reforms. For example, we know that many states will conduct reviews for the following: coverage of EHB, including formulary reviews for EHB purposes; compliance with actuarial value (AV) and market rating reforms; and rate increases, consistent with state authority and federal law. Accordingly, CMS will not duplicate state reviews where a state is enforcing these and other Affordable Care Act standards. CMS will evaluate QHPs against all other certification standards. The list of certification standards is included in the State Partnership guidance linked above.			
States	**Q45:** If our product form filings are "deemed" approved by the appropriate state regulatory authority because our state failed to timely review them in accordance with state law, will the Exchange consider the product approved by the state?	**A45:** Yes. If a product can be considered "approved for sale" in a state pursuant to the terms of a deemer clause under state law, the FFM will accept the issuer's attestation that the product has been approved for sale by the State Department of Insurance.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
States	**Q46:** Should issuers complete HIOS or	**A46:** The order does not matter, but if the state is the primary reviewer, HHS	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_06281

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	SERFF uploads first?	would generally expect the issuer to submit to the state first.			3.pdf
Plan Compare/Website	**Q47:** Are issuer's member-facing websites required to be 508 compliant if they participate on the Exchange?	**A47:** No. 45 CFR 156.250 establishes standards for issuer applications and notices, but not websites.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Plan Compare/Website	**Q48:** Will the FFE support mobile devices?	**A48:** As stated in chapter 6 of the final Letter to Issuers on Federally-facilitated and State Partnership Exchanges, released on April 5, 2013 and available on the CCIIO website at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf the FFE "website will be provided in a mobile-friendly format using responsive design techniques."	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Plan Compare/Website	**Q49:** What elements will the Exchange combine to form plan display names?	**A49:** The plan name will be displayed as [Issuer Marketing Name + Plan Marketing Name + Plan type]. The combination of these plan attributes make up the plan name in that order. The final name that will be displayed on the marketplace will be displayed in this format.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Cost Sharing	**Q50:** For plan 03 (AI/AN above 300% FPL), are issuers required to only	**A50:** 45 CFR 156.420(b)(2), as described in the final Payment Notice (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf),	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	apply the $0 cost share to Tribal providers to the on exchange states?	requires QHP issuers to offer a limited cost sharing plan variation with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services – regardless of the state in which the coverage is provided, or the state in which the provider is located. Please see Q84 of QHP FAQ #9 for additional information.			
Cost Sharing	**Q51:** Can individual plans gain relief using the MOOP "safe harbor" referred to in the February 20 FAQ similar to group plans?	**A51:** No. The one-year transitional exemption from the ACA's MOOP limitations does not apply to individual market plans. It only applies to small and large group market plans and self-insured plans that use multiple benefit administrators.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Systems/HIOS	**Q52:** Do issuers have to close all Product IDs and request new IDs for the QHP application submission?	A52: No. Products should only be closed if they are being removed from the market. If QHPs are being created based on existing filings and HIOS products, they can use those product IDs and related standard component IDs. If new filings are being done to support the creation of QHPs, those filings should have an equivalent new product filed in HIOS, and standard component IDs generated to submit the QHPs.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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Systems/HIOS	**Q53:** At what point is the HIOS Plan ID generated?	A53: After an issuer has reported the product filings as Products in HIOS, Standard Component IDs (plan IDs) can be generated. This should precede filling out the QHP templates for submission to the FFM or an SBE.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
HPID	**Q54:** Are QHPs required to get a Health Plan Identifier (HPID)?	**A54:** HPIDs are not required for certification of QHPs.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
HPID	**Q55:** Will the "Associated HPID" field within the Administrative Data Elements section be a required field?	**A55:** It is not currently a required field. Issuers may need to provide this identifier at a later date.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
HPID	**Q56:** How can issuers receive information about our HPID?	**A56:** Now that the HPOES Module is open in HIOS, an issuer can enter the module to request an HPID. An issuer will receive an HPID when the process is completed.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Benefits Template	**Q57:** Where do issuers supply what an estimated payment would be for the three CSR variations of each Silver plan?	**A57:** As discussed on page 15487 of the final Payment Notice (http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf), for the 2014 benefit year, the advance payment estimates for the silver plan variations and the zero cost sharing plan variations will be developed using a methodology that utilizes data that QHP issuers submit for other purposes – specifically, the expected allowed claims cost (from the Unified Rate Review Template) and the actuarial	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		value (from the Plans and Benefits Template). As a result, issuers would not be required to submit any additional data or supporting documentation to receive advance payments in benefit year 2014 for the value of the cost-sharing reductions that would be provided under the silver plan variations or the zero cost sharing plan variation. However, if a QHP issuer wants to receive advance payments for the value of cost-sharing reductions provided under the limited cost sharing plan variation, the QHP issuer must submit an estimate of this advance payment amount through the Plans and Benefits Template, along with a justification for the estimate (see Chapter 13i of the QHP application instructions).			
Benefits Template	**Q58:** How do issuers enter the combined In/Out of Network MOOP and Deductible? What about the Combined In/Out of Network Medical/Drug EHB deductible?	**A58:** If the plan has separate MOOPs or deductibles, it would enter these separately on the benefits template. If the plan only has a combined (no in network) MOOP (or deductible), either all of the plans in a benefits package need to set their in network MOOP (or deductible) to a dollar value, or they all need to set their in network MOOP (or deductible) equal to Not Applicable and set their combined in/out network MOOP (or deductible) to a dollar value.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Benefits Template	**Q59:** In order to qualify for the 2014 safe harbor for small	**A59:** A QHP can be structured with combined or separate OOP amounts for medical and pharmacy. The OOP	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	group plans, must the MOOP for medical and pharmacy total less than $6350, or must each independently be less than $6350?	limitations apply to non-grandfathered individual and small group market plans, requiring that the combined OOP or the total sum of the separate medical and pharmacy OOPs do not exceed the statutory limitation of $6350 for 2014. Some small group market plans which have separate medical and pharmacy MOOPs may qualify for a one-year exemption from the statutory MOOP limits if the major medical and pharmacy (or other EHB benefit) are separately administered. In such cases, and solely for group market plans 2014, each of these MOOPs is separately subject to the statutory limits, such that they medical MOOP must not exceed the $6350 limit and the separate pharmacy MOOP cannot exceed the $6350 limit. Please see the Letter to Issuers on Federally-facilitated and State Partnership Exchanges released on April 5, 2013.			
Benefits Template	**Q60:** Can we submit multiple plans in a single benefits tier (for example, 3 silver plans), using the templates?	**A60:** Yes, you can submit and offer multiple benefit plans at the same level of coverage (e.g., silver, bronze). All plans defined within a Benefits Package will share the same set of benefits and limits but may differ in cost sharing. To offer a different set of benefits and limits, you will need to create a new Benefits Package. Please refer to Chapters 10 in our instructions guide for more details which is available on the	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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		CMS zONE online repository at https://zone.cms.gov/ or on www.REGTAP.info.			
Benefits Template	**Q61:** Should the coinsurance reflect what the member will pay or what the insurer will pay?	**A61:** On the Plan and Benefits template, the coinsurance amounts should reflect what the member will pay.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Benefits Template	**Q62:** My template validated successfully, but when I uploaded it, I got a validation error requesting a valid EHB variance reason. How can this be fixed?	**A62:** For state mandates that are market-specific, the template populates the benefits based on the market and validates the mandates as EHB. However, the upload validation only considers these benefits to be EHB when they are mandated in both markets. Therefore, if your state has market-specific mandates, you will be asked to submit an EHB variance reason when you submit one of the market-specific state mandated benefits. In this case, the EHB variance reason should be "Additional EHB Benefit."	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Benefits Template	**Q63:** In the "Plan Type" column of the Plan & Benefits Template, what does "EPO" mean?	**A63:** EPO refers to an Exclusive Provider Organization.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Benefits Template	**Q64:** If an issuer has a major medical plan where the member	**A64:** If a copayment is charged for a benefit, enter the dollar amount in the copay field. If no copayment is charged,	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	pays 100% out-of-pocket until the deductible is met, but then 0% is paid by the member once meeting the deductible, how does an issuer enter this in the Cost Sharing fields?	choose from *No Charge*, *No Charge after deductible*, *$X Copay*, *$X Copay after deductible*, or *$X Copay before deductible* in the Plan & Benefit Template. If coinsurance is charged for a benefit, enter the percentage in the coinsurance field. If no coinsurance is charged, enter *No Charge*, unless your plan has a tier 1 copayment that the enrollee pays only until the deductible is met. In this case, enter *0%*. Choose from *No Charge*, *No Charge after deductible*, *X% Coinsurance after deductible*, or *X%* Plan & Benefit Template. Issuers may refer to Chapter 10: Instructions for the Plans & Benefits Application Section for additional information.			
Benefits Template	**Q65:** If the plan does not pay for a benefit but the members are entitled to a discount on the services since they are a member, would this be considered a covered benefit?	**A65**: Benefits may only be included in the Plan and Benefits template if the issuer covers all or part of the service. Discounts on services or products that come with the coverage would not be considered covered benefits.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Rating Template	**Q66**: Do issuers need to submit two sets of HIOS rate sheet templates (one with on exchange plan codes and one with	**A66:** HHS cannot comment on how SBEs are prepared to combine data. In general, rate tables are stored and calculated based on QHP IDs (standard component IDs generated in HIOS). QHPs are submitted exclusively to the	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	off exchange) even though the benefits and rates are the same?	FFM, and the integration of on and off-exchange plans is not an issue. HHS would anticipate that rate tables need to be submitted based on Standard Component IDs. HHS might expect an SBE to ask for two templates (one for QHPs, one for off exchange), but that is simply an expectation.			
	Q67: The regulations allow for a 1.5:1 rate factor for tobacco use. However, the Rate Template does not allow for this and errors out because the spread in some instances is more than 3:1 by age. For example, take a 21 year old smoker and a 64 year old smoker, you might have a 1.10 smoking factor for the 21 year old and a 1.30 factor for the 64 year old smoker. When you apply the age factors, the 64 year old smoker would have a rate that is more than 3 times higher than the 21 year old smoker. Will there be	A67: The preamble to the Health Insurance Market Rules Rate Review final rule (Market Rule), published on February 27, 2013, states that younger enrollees could be charged a lower tobacco use factor than older enrollees provided the tobacco use factor does not exceed 1.5:1 for any age group. For example, a 21-year-old smoker could be rated at 1.2 to 1 and a 65-year-old smoker can be rated in the same plan at 1.5 to 1. Because of a system limitation in the Rating Tables Template, however, the system currently cannot process a premium for a 65-year-old smoker that is rated more than 3 times the premium of a 21-year-old smoker. Accordingly, HHS asks that, until further notice, all issuers that are required to use the Rating Tables Template and that will be offering non-grandfathered plans in the individual and small group markets implement the tobacco rating factor for their non-grandfathered policies so that older adult smokers are not rated in total	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf

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	an opportunity to updates the rates issuers submitted during the application window?	more than 3 times of the total rate for a younger adult smoker. One way to accomplish this is if an issuer imposes a 1.2 to 1 tobacco rating factor on a 21-year -old smoker, the issuer should use the same 1.2 tobacco rating factor for the 65-year-old smoker. If an issuer implements the tobacco rating factor with the result that an older smoker is rated up more than 3 times of that of a younger smoker, the submission of the issuer will be rejected by the system. HHS intends to implement a system change that will allow for processing of tobacco rating factors that vary based on age, and HHS expects this to be completed after calendar year 2014. HHS also reminds issuers that the Market Rule provides that a tobacco rating factor may be applied only with respect to individuals who may legally use tobacco under federal and state law. Different states may have different age limits regarding the sale of cigarettes. If a state, for example, prohibits the sale of cigarettes to individuals under the age of 19, then individuals under the age of 19 in that state cannot be rated for tobacco use. Therefore, health insurance issuers seeking to impose tobacco rating should be aware of the age limit in every state where they will offer health insurance coverage subject to tobacco premium rating.			

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URRT	**Q68:** If an issuer is entering a market for the first time and has no experience, how should they input information on Worksheet 1 of the Unified Rate Review Template under the Section 1: Experience Period and how will the results be published?	**A68:** Issuers have to input a number greater than $0, which was an unintended error in the template. HHS does not know how information will be published at this time, but as required by rule, issuers will be notified before we publish and given the opportunity to make comments and/or seek a confidentiality exemption for information determined to be published.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
URRT	**Q69:** How do issuers enter Product IDs on past experience for terminated plans in the URRT?	**A69:** Most products in the individual market have been required to be submitted to the HIOS Plan Finder for over 2 years and over 1 year for the small group market, so HHS anticipates that most issuers will have at least 1 Product ID to input for terminating products. If not, the issuer will be required to seek a Product ID from HIOS and that request will be handled as quickly as possible.	FAQ #2 June 28, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ12_062813_5CR_062813.pdf
Form 5500 Counting Method	**Q1:** In the HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15410), we set forth several counting methods for contributing entities to determine the	**A1:** Yes. HHS notes that 45 CFR 153.405(e)(3), which describes a counting method based on Form 5500, uses the term “benefit year” (defined in 45 CFR 155.20 as a calendar year for which a health plan provides coverage for health benefits), which is not necessarily the basis on which the enrollment count for Form 5500 is	FAQ May 28, 2013	CMS	https://www.regtap.info/uploads/library/PMQHP_FAQ11_052813_5cr_052913.pdf

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	number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year. Can a self-insured group health plan with a plan year other than the calendar year use the counting method set forth in 45 CFR 153.405(e)(3), based on the number of covered lives reported on Form 5500?	reported. We clarify that a self-insured group health plan may use the Form 5500 counting method, even if its plan year is not the calendar year.			
Cost Sharing	**Q1:** Do issuers need to update their maximum out-of-pocket and deductible values for certain plans now that the IRS has published the 2014 out-of-pocket limits for high deductible health plans (HDHP)?	**A1:** The annual limitation on cost sharing (commonly referred to as a maximum out-of-pocket limit) for 2014 is $6,350 for self-only coverage and $12,700 for other than self-only coverage. This affects the allowable maximum out-of-pocket value for Essential Health Benefits for all plans submitted in a QHP application. It also affects the allowable deductible value for catastrophic plans. These limits are slightly lower than the CMS estimates published on April 5, 2013 in the "Letter to Issuers on Federally-facilitated and State Partnership Exchange." Issuers that have submitted qualified health plan (QHP) applications	FAQ May 28, 2013	CMS	https://www.regtap.info/uploads/library/PMQHP_FAQ11_052813_5cr_052913.pdf

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		to State Regulators or CMS with maximum out-of-pocket values above $6,350 for self-only coverage or $12,700 for other than self-only coverage will need to revise their applications. If an issuer used the CMS 2014 estimated limit of $6,400 and $12,800, the maximum out of pocket values will only need to change by $50 or $100, respectively, which will have a very minor impact on actuarial value. It is unlikely that plans in this situation will need to make changes to other cost sharing data elements in order to meet an actuarial value for a given level of coverage under 45 CFR § 156.140.			
Cost Sharing	**Q2:** When should an issuer participating in a Federally-facilitated Marketplace (FFM) revise their application?	**A2:** Issuers have already submitted their QHP applications to CMS through the Health Insurance Oversight System (HIOS) and some plans may be out of compliance with the limits for maximum out-of-pocket or deductible values. Issuers in States enforcing the Affordable Care Act market reforms, including the annual limitation on cost sharing, should contact their State Regulator regarding the process and timing for correcting and resubmitting their applications. In States in which CMS is directly enforcing the Affordable Care Act market reforms, CMS will be contacting those issuers and requesting revisions to their applications.	FAQ May 28, 2013	CMS	https://www.regtap.info/uploads/library/PMQHP_FAQ11_052813_5cr_052913.pdf

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Cost Sharing	**Q3:** When should an issuer participating in a State Partnership or State Based Marketplace revise their application?	**A3:** The issuer should contact their State Regulator regarding the process and timing for correcting and resubmitting their applications if an issuer has already submitted a QHP application to a State Partnership or State Based Marketplace that does not comply with the limits for maximum out-of-pocket or deductible values.	FAQ May 28, 2013	CMS	https://www.regtap.info/uploads/library/PMQHP_FAQ11_052813_5cr_052913.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q1:** How will the FF-SHOP prevent a new group from enrolling into an HMO plan when out-of-state?	**A1:** There will not be a mechanism in place in 2014 to prevent an employer from enrolling in a plan without network access. There will be a comparison tool on HealthCare.gov providing plan-specific information to enrollees. Employers and employees will be able to navigate to Issuers' websites for provider network information. CMS will work with Issuers to ensure educational information is provided to employers about the consequences of selecting a QHP for their employees that does not provide network access for an out-of-state employee's primary worksite.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q2:** What role will Agents and Brokers play in the FF-SHOP?	**A2:** Agents and Brokers will play a key role in the FF-SHOP—helping employers and employees understand the SHOP Marketplace and assisting them complete online applications for coverage. Please refer to this resource document for additional information on the role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q3:** 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?	**A3:** As proposed in the Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards published on June 19, 2013 (Federal Register / Vol. 78, No. 118), the geographic area premium rating factor must be based on the group policy holder's principal business address in each state. This approach would apply both inside and outside of the FF-SHOP.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q4:** Can an employer participate in multiple SHOPs?	**A4:** Multi-state employers may participate in multiple SHOPs [see 45 CFR § 155.710(3)], however, an employer will be limited to establishing one FF-SHOP account per state.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q5:** How will out-of-state employees be counted when assessing participation requirements?	**A5:** Employers with worksites in more than one state may establish either one FF-SHOP account serving all work locations or establish multiple SHOP accounts in each state where employees have a primary worksite. When one account is established, employees in all states will be considered when calculating an employer's FF-SHOP participation rate. When multiple accounts are established, employees on each employee roster in each state will be considered separately when calculating an employer's FF-SHOP participation rate.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q6:** How may QHPs differ for employers offering QHPs in multiple SHOPs?	**A6:** Network requirements, service areas, etc. of a QHP will be determined by the SHOP certifying the QHP. If an employer allows out-of-state employees to enroll in a QHP through a SHOP serving the employee's primary worksite (and not the SHOP serving the employer's headquarters), then the employee will receive coverage through a QHP that may have a different premium, benefit benchmark, rating criteria, etc., than a QHP certified through the SHOP serving the employer's headquarters.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q7:** Will the FF-SHOP be verifying members for dual coverage (coverage on more than one	**A7:** The FF-SHOP is expecting a response for each employee on the roster (e.g., whether the employee has other group coverage or public coverage, etc.).	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	group or individual plan) when calculating participation percentages?				
Federally-Facilitated Small Business Health Options Programs- Eligibility & Participation Requirements	**Q8:** Will an employer be able to participate in the FF-SHOP if it does not meet the 70 percent minimum participation requirement?	**A8:** For coverage effective January 1, the guaranteed availability requirements in the Public Health Service Act (PHSA) § 2702 will apply, as required in 45 CFR § 147.104(b)(1)(i). During this special enrollment period (November 15 - December 15), an employer is not subject to a minimum participation requirement and any employer otherwise qualifying for FF-SHOP coverage will be able to enroll in the FF-SHOP regardless of its level of employee participation. Outside of this period, the minimum participation requirement will be enforced for new groups applying for FF-SHOP coverage. This guaranteed availability requirement will be in effect as of November 15 - December 15, 2013. Outside of the annual special enrollment period, the FF-SHOP will hold an employer's application until the employer meets the 70 percent minimum participation requirement (or the threshold required in that employer's state). The FF-SHOP will not send any information to Issuers until the group has met the minimum participation requirement.	FAQ July 5, 2013	CMS	

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Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q9:** Will groups not meeting the minimum participation rate be able to reapply within the same calendar year?	**A9:** Yes. An employer can reapply within the same calendar year. The FF-SHOP will re-open the enrollment period for those wishing to reapply.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q10:** Will groups falling below the minimum participation rate during a plan year be allowed to continue their participation in the FF-SHOP throughout the plan year?	**A10:** Yes. The FF-SHOP will only check minimum participation rates one time per year, i.e., at initial enrollment and at renewal for the next plan year.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q11:** If an employer in the FF-SHOP signs up during the November 15 – December 15 annual enrollment period, will the employer need to meet the minimum participation requirement upon renewal?	**A11:** Yes. The FF-SHOP will require all employers renewing the same QHP to meet the applicable minimum participation rate upon renewal.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q12**: In cases where an employer is reapplying for coverage, and employees apply	**A12:** When a new offer of coverage is made, employees will need to reapply for coverage and respond to the new offer. However, any information saved during the initial application will remain	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	after the close of the employer's open enrollment period, will all the other employees that previously applied need to reapply?	saved and the employee can use this information when reapplying for FF-SHOP coverage.			
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q13:** Will the FF-SHOP support, require, or disallow coverage of retirees?	**A13:** Yes. The FF-SHOP allows for coverage of retirees. This information will be reported on 834 enrollment transactions under the category of retirees. Retirees will not receive a different contribution amount through the FF-SHOP from other enrollees. All retirees, active employees, and dependents will be rated using the same under the standard age curve.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q14:** Will retirees be counted when determining the minimum participation rate?	**A14:** If a retiree is on an employer's roster, he or she will be included in the denominator of the minimum participation percentage equation.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health Options Programs-Eligibility & Participation Requirements	**Q15:** Will the FF-SHOP collect data regarding employees currently in their waiting period? Will these employees count toward the SHOP minimum participation requirement?	**A15:** For initial FF-SHOP applications, any employee on the roster submitted by an employer will be eligible for coverage on the effective date of coverage for the group. Waiting periods will only be considered for new employees added to the roster after coverage has been effectuated for the group.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Federally-Facilitated Small Business Health	**Q16:** Will the FF-SHOP support	**A16:** To the extent over age disabled dependent coverage is required under	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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Options Programs-Eligibility & Participation Requirements	coverage for over age disabled dependents?	state law and this requirement was reported by Issuers on their QHP applications, the FF-SHOP will support coverage for over age disabled dependents.			
Group Application	**Q17:** Will the FF-SHOP allow multiple billing addresses for an employer group?	**A17:** No. The FF-SHOP will not allow multiple billing addresses for an employer group, however, a secondary contact may receive a copy of notifications sent to the primary contact.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Group Application	**Q18:** Will the FF-SHOP collect ERISA status information for the group?	**A18:** The FF-SHOP is collecting standardized data on the types of groups enrolling, e.g., private sector-C corporation, governmental, etc. but will not collect ERISA status information for each group. See http://www.reginfo.gov/public/servlet/ForwardServlet?SearchTarget=PRA&textfield=0938-1193 for the SHOP employer online questionnaire and associated data elements.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Group Application	**Q19:** Will the FF-SHOP allow multiple classes of employees (owners, salaried, hourly) for an employer group?	**A19:** No. The FF-SHOP will not allow varying coverage for different classes of employees.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Group Application	**Q20:** What business rules can the employer specify for enrolling employees? (E.g., full-time only, no dependents, certain locations	**A20:** Employers participating in the FF-SHOP are required to offer coverage to all full-time employees (those working on average 30+ hours per week). Depending on state law, dependent coverage is optional when an employer establishes a group policy. Thus, an	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	only, waiting period for new hires, etc.) How will the employer specify the business rules for enrolling employees?	employer may be able to choose to offer employee-only coverage in the FF-SHOP and exclude dependents from enrolling. In terms of limiting coverage to certain geographic locations, the Patient Protection and Affordable Care Act requires all employers applying for FF-SHOP coverage to offer coverage to all full-time employees, regardless of geographic location, as a condition of FF-SHOP participation. (See 45 CFR § 155.710 Eligibility standards for SHOP) As part of the initial application process, an employer will specify employees eligible for coverage on the employee roster. Issuers will only receive information on those employees who enroll from the roster. After the initial application, enrollment information passed to Issuers will already have factored in applicable new hire waiting periods and will specify when coverage must be effectuated.			
Group Application	**Q21:** How will the FF-SHOP capture any paper / documentation collected from an employer that needs to be provided to an Issuer and how will the FF-SHOP send the attachments (Example: Group	**A21:** In year one, contractual documents will not be transmitted through the FF-SHOP and will be handled separately between the employer and Issuer. It is CMS's intention to amend this process in the future.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	Contract) to Issuers?				
Group Application	**Q22:** The draft paper employee application does not allow for dependents. Will this be corrected or will the online experience be required to cover dependents?	**A22:** Yes. Dependent coverage will be collected in the online experience. The paper application is an eligibility determination document that collects only employee-level information. The enrollment process for employees and dependents must be completed online. See http://www.reginfo.gov/public/servlet/ForwardServlet?SearchTarget=PRA&textfield=0938-1194 for the SHOP employee online questionnaire.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
COBRA	**Q23:** Will a group's existing COBRA members be calculated in the minimum participation rate for SHOP?	**A23:** An employer's roster of eligible employees will include COBRA enrollees. Thus, COBRA enrollees will be included in minimum participation rate calculations.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
COBRA	**Q24:** Will a group's existing COBRA members be rated in the FF-SHOP?	**A24:** Yes. A group's existing COBRA members identified on the employee roster will have premiums calculated in the FF-SHOP based on allowable rating factors, i.e., age and tobacco usage.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
COBRA	**Q25:** If an employer is allowed to enroll employees in COBRA, who (employer or employee) will pay the COBRA premium?	**A25:** Current insurance market standards and protocols for notifying employees and paying for COBRA coverage will remain unchanged in the FF-SHOP in 2014. For 2015 when the FF-SHOP will provide billing and payment services for all FF-SHOP employers, COBRA premiums will be	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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		included on the single employer invoice and employers will be expected to remit the full amount owed by the due date and no later than the end of the grace period.			
Effectuating Coverage	**Q26:** How will an employer select a new hire's waiting period prior to effectuating coverage?	**A26:** An employer will establish the group's new hire waiting period policy during the initial application process. There will be a drop-down box in the online employer application where the employer will select the waiting period. The available options will be 0, 15, 30, 45, and 60 days. Because coverage for new hires is always effectuated on the first of the month, the maximum waiting period option will be 60 days to ensure an employee's waiting period does not extend beyond the maximum allowable period of 90 days. Issuers will not receive the waiting period start and end dates. Only the effective dates of coverage for new hires (incorporating applicable waiting periods) will be sent to Issuers.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Effectuating Coverage	**Q27:** Since the FF-SHOP will not be calculating participation rates during the November 15-December 15 special enrollment period, will Issuers receive a single enrollment file or a	**A27:** The FF-SHOP will send Issuers groups' enrollment files during this period in the same manner as will occur during the rest of the open enrollment period.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	separate enrollment file for employers applying during this period of time?				
Effectuating Coverage	**Q28:** The payment redirect transmittal will include an effective date for proposed coverage, which is the date (mm/dd/yyyy) by which coverage will begin, assuming timely payment of the initial premium. Would an Issuer be required to effectuate coverage without receiving the first month's premium payment prior to the coverage effective date?	**A28:** Unless a state law requires otherwise, Issuers will not be required to effectuate initial group coverage without receiving the first month's premium payment prior to the coverage effective date.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Effectuating Coverage	**Q29:** Will Issuers be allowed to pend employee enrollment until the employer meets the required participation threshold?	**A29:** Pending employee enrollment will not be necessary since Issuers will not receive the group set up file or 834 enrollment transactions until the employer meets the participation rate.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Effectuating Coverage	**Q30:** Since the FF-SHOP will require the employer to select a single QHP	**A30:** The effective date of coverage is based on the employer selection of a QHP during the initial application process. For special enrollment periods,	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	for employees in year 1, are the effectuation timeframes in 45 CFR § 156.260 tied to an employer selection or employee selection?	the effectuation date will depend on the employee's specific situation. See 45 CFR §155.420(d) for applicable employee circumstances.			
Broker Issues	**Q31:** The FF-SHOP indicated that commissions for groups sold through the FF-SHOP must be similar to commissions sold outside the FF-SHOP. Does this apply to an Agent who is not appointed by an Issuer?	**A31:** Unless state law requires otherwise, an Issuer would not be expected to pay a commission to a Broker who is not appointed with the Issuer.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Broker Issues	**Q32:** What measures will be in place to ensure that a Broker is certified and authorized to service an employer in the FF-SHOP?	**A32:** Consistent with 45 CFR § 155.260, an Agent or Broker operating in the FF-SHOP is required to sign a privacy and security agreement with the Marketplace. While Agents and Brokers operating in the FF-SHOP will be encouraged to complete Marketplace training, the final Exchange regulations do not require such training as a condition of participation in the FF-SHOP.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Broker Issues	**Q33:** What happens if a Broker attempts to create a quote for	**A33:** The FF-SHOP is not taking responsibility for competition between Brokers for employer business. It is the	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	an employer after another Broker already started the workflow for that employer?	employer's decision to work with a particular Broker and to enter the appropriate name and National Producer Number of the Agent or Broker associated with the employer application when applying online.			
Broker Issues	**Q34:** Can the employer add, change, or remove an associated Broker within the FF-SHOP? If the answer is yes, what security will be in place to ensure that the Broker is authorized to work with the employer?	**A34:** CMS intends to allow an employer enrolled in FF-SHOP coverage to add, change, or remove the Broker of record from within his or her secure My Account. Only a validated employer can make a Broker of record change.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Broker Issues	**Q35:** Can one Broker work with some employees in a group while a different Broker works with other employees within the same group?	**A35:** No. The employer determines the Broker relationship. All employees will have the same Broker associated with a SHOP employer.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Broker Issues	**Q36:** What happens when a Broker ceases to provide service to the employer group due to retirement, loss of license, etc.?	**A36:** It is the responsibility of the employer to manage the Broker/employer relationship. If a Broker retires or loses his or her license, the employer will need to find an alternate Broker.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Renewals	**Q37:** How will	**A37:** Renewal information in the FF-	FAQ July 5,	CMS	https://www.regtap.info/uploads/library/

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	renewals work in the FF-SHOP?	SHOP can found in the final regulations at 45 CFR §155.725. The FF-SHOP will be managing renewal notifications, and CMS intends to involve Brokers in the renewal process. Employers will be notified of the option to renew SHOP coverage 90 days prior to the end of the plan year. At that time, the employer will be given a 30-day window to make employer-level changes. After the employer makes necessary changes, employees will be given the next 30 days of the 90-day renewal window to make their coverage selections for the new plan year. If the employer elects to have the same coverage for the following plan year, employees will be automatically renewed into the same QHP unless they take other action during their renewal timeframe. The remaining 15 days can be used to follow up with late renewals and process enrollment applications, which need to be submitted 15 days prior to the start of the new plan year.	2013		SHOP_Issuer_FAQs2_5CR_070813.pdf
Other Reporting	**Q38:** As stated in 45 CFR § 155.720(i), the FF-SHOP is required to report to the IRS on employer participation, employer contribution, and employee enrollment information in a time	**A38:** 45 CFR § 155.720(i) does not place a reporting requirement on Issuers to the FF-SHOP.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	and format to be determined by CMS. What employer contribution information are Issuers required to report to the FF-SHOP? How will this information be collected?				
Shopping Experience	**Q39:** Can you describe the process for the employer to pick a product to offer employees? Can the employer run "what if" premium cost scenarios?	**A39:** As part of the application process, an employer will be able to enter basic demographic information on employees and dependents likely to participate in an employer group's FF-SHOP plan and be able to run "what if" premium scenarios.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Shopping Experience	**Q40:** If an employer group in the FF-SHOP allows coverage of domestic partners but an Issuer's business rules do not cover domestic partners, will the plans be excluded from the available options?	**A40:** The QHP application process provides information on which dependents are required to be covered in a state. Depending on how an Issuer responded to allowable dependent coverage questions on its QHP application, the domestic partner relationship identifier would be populated in the list of available dependent relationship identifiers on the employee online application. Issuers would be expected to cover required dependents accordingly.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Shopping Experience	**Q41:** For the FF-SHOP, will Issuers	**A41:** No. Issuers will not have the ability to impose minimum contribution	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf

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	have the ability to impose contribution rates, even though CMS is not setting a specific contribution amount?	rates for groups participating in the FF-SHOP. CMS may provide educational information to employers—alerting them of any state minimum contribution requirements. For states with a minimum contribution requirement, the statute and pertinent market rules do not allow for a minimum contribution requirement during the November 15 – December 15 annual special open enrollment period.			
Summary of Benefits and Coverage (SBCs)	**Q42:** Can CMS describe how an Issuer's Summary of Benefits and Coverage (SBCs) will be made available to a group's benefits administrator and to a group's members during open enrollment for the FF-SHOP?	**A42:** Existing Issuer requirements regarding making Summary of Benefits and Coverage (SBCs) available to a group's benefits administrator and a group's members have not changed.	FAQ July 5, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_Issuer_FAQs2_5CR_070813.pdf
Enrollment & Transaction	**Q1:** Will subscribers who are eligible for the Advance Premium Tax Credits (APTC) but elect $0 APTC, still qualify for the 90 day grace period for non-payment of premiums?	**A1:** No. Per § 156.270(d) of the Exchange Final Rule, the enrollee must be *receiving* APTC to qualify for the 3 month grace period.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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Enrollment & Transaction	**Q2:** How does the Marketplace expect health plans to handle distribution of the Summary of Benefits and Coverage (SBCs)? Regulation requires SBCs to be sent to applicants within 7 days of submitting the application. Will there be exceptions for Exchange enrollment? If yes, what are the exceptions? Will the Exchange be able to get enrollment to the carriers in time for carriers to make the 7 day requirement?	**A2:** The Issuers are still expected to distribute the SBCs in accordance with current law; within seven days of QHP issuer receipt of the enrollment transaction from the FFM. The Federally-facilitated Marketplace (FFM) does not anticipate the need for exceptions because Issuers will receive the enrollment transaction within the same 24 hour period as the enrollee makes his/her selection of QHP – or submission of the application. Thus, the FFM will be getting enrollment to the Issuers in time to meet the 7 day requirement.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q3:** Will the FFM or the Issuer have the responsibility for terminating over age dependents? Who will own the notice requirements related to determination? Given the policy holders Advance	**A3:** We are developing guidance on the subject of terminations for over age dependents and will release that to Issuers soon.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	Premium Tax Credit (APTC) will be impacted, what is the requirement for the timing of a new Exchange eligibility determination? If the issuer owns such determinations, how should notice be provided to the FFM in the 834, and what is the process for maintaining coverage in the case of disability, or state law requiring maintaining of coverage (e.g., full-time students, veteran's, etc.)?				
Enrollment & Transaction	**Q4:** This is a question about pro-ration. The subscriber, eligible for Advance Premium Tax Credits and/or Cost Sharing Reductions (APTC/CSR), is cancelled mid-month due to death. The APTC/CSR has already been paid to	**A4:** IRS just recently published proposed rulemaking on this topic. CMS is working with the IRS on the disposition of refunds for APTC/CSR under various scenarios. We anticipate discussing this topic on an upcoming issuer engagement call.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	the issuer for the month. Firstly, does the carrier have to refund the APTC? If yes, is the refund calculated on a pro-rated basis? Or is it refunded retro-actively to the beginning of the month? Does the policy apply to the CSR? Secondly, for the CSR, which will be reconciled annually, does the refund get processed and paid throughout the year as events occur, or will it be part of the yearly reconciliation process that occurs after the calendar year and the claims run out period?				
					https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q5:** For the State Based Marketplace (SBM), is the ASC X12 834 enrollment transaction sent to	**A5:** SBMs have various business models. Some SBMs collect/aggregate the initial month's premium, and therefore may not require a "confirmation" (effectuation)	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	the FFM at the same time it is sent to the Issuer? Or does the SBM wait until the issuer has confirmed receipt of the 834 and "effectuated" coverage before they send the 834 to the FFM?	transaction from Issuers. SBMs will determine the timing of their transactions to CMS.			
Enrollment & Transaction	**Q6:** With respect to the SHOP program, is there a possibility that a benefit year will not match a contract year? Will Issuers be permitted to have benefit years that differ from the contract years for small groups?	**A6:** The benefit and contract years must align for small groups	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q7:** Name Normalization: On the ASC X12 834 enrollment file, will the Federally-facilitated Marketplace (FFM) be performing any name normalization? If so, will an enhanced character	**A7:** The Federally-facilitated Marketplace will not be performing name normalization, and no enhanced character set is planned for use with the ASC X12 834 enrollment transaction. The member's name cannot be changed based on information obtained by name normalization on the issuer side; however, the issuer can report such information during reconciliation. An individual who wishes to correct	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	set be used? Can the member name sent from the Marketplace be changed (based on name normalization on the issuer side)?	personal information such as his or her name must do so through the FFM.			
Enrollment & Transaction	**Q8:** Can multiple acknowledgement files (999) be sent back for one incoming enrollment file?	**A8:** Yes, Issuers may send multiple acknowledgement files (999s) back for one incoming (physical) enrollment file.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q9:** Can the TA1 and 999 acknowledgements for the ASC X12 834 enrollment file be sent together?	**A9:** Yes, Per the ASC X12 Implementation Guides, a TA1 can be included in an interchange with other functional groups and transactions.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q10:** When we will be able to sign Trading Partner Agreements?	**A10:** The Trading Partner Agreement process is under development. Background information and current updates about the Trading Partner Agreements can be found on the Issuer Community in the zONE.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q11:** On the initial enrollment file layout, as indicated in the most recent CMS/FFE Enrollment	**A11:** The CMS Enrollment Companion guide is to be used in conjunction with the applicable ASC X12 Implementation Guide TR3. A data element is included in the Companion Guide to provide unique or specific	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	Companion Guide (v 1.5 from March), the only date that is indicated is at the file/transaction level. There do not appear to be any member or coverage level dates in the initial enrollment 834 from the FFE, only the transaction date. Is this is intentional or an oversight? Shouldn't the FFE be sending member (2000 loop) and coverage (2300 loop) dates in the initial enrollment 834? Is the FFE intentionally not sending dates - as the date is determined by receipt of payment and EARLIEST effectuation date within the carrier's system? If yes, are there any guidelines regarding whether the EARLIEST effectuation date is the beginning of the next month? Or the	information about how the date would be used by the FFM. Dates will be included in transactions when applicable (required by the TR3).			

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	beginning of the month following the next month?				
Enrollment & Transaction	**Q12:** How will carriers identify Tribal members if they are not enrolled in an American Indian /American Native (AI/AN) plan variation?	**A12:** There are no standard ways by which an issuer will be able to identify a tribal member, unless the individual self-identifies in the application and therefore selects and enrolls in an AI/AN plan. CMS will not provide a flag for tribal members. However, we would be interested in further discussion to understand if and why Issuers need to know if someone is a tribal member if they are not enrolled in an AI/AN plan.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q13:** Regarding the reporting of dollar amounts in the 2750 REF02 field, do dollar amounts always need to include two places to the right of the decimal? Also please confirm that a $ dollar sign does NOT need to precede the REF02 amounts.	**A13:** Yes, the dollar amounts do need to include two places to the right of the decimal, and the $ sign does **not** need to precede the REF02 amounts. CMS will not send the dollar sign in the enrollment transactions. This information has been updated in the CMS Enrollment Companion Guide.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q14:** What is the list of special enrollment period reasons, and how will these be	**A14:** The Special Enrollment Reason codes that will appear on the 834 enrollment transaction include the items below. These codes will be used in the	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

Category	Question	Answer	FAQ Title	Agency	Site
	used on the ASC X12 834 enrollment transaction? Will the CMS Enrollment Companion Guide list them in Table 12?	individual Member Reporting Category Loop (See page 57 of the Version 5010 Implementation Guide). The identifier in the REF01 "17" says it is a Client Reporting Category, which points to the N102 segment containing a value for the "SEP REASON. This list will be included at the end of the updated version of the Companion Guide. The SEP Reason codes are as follows: (1) Qualified Individual (QI) or dependent loss of Minimum Essential Coverage (MEC); 07-Termination of Benefits, located in the INS04-Maintenance Reason Code. (2) QI gains or becomes a dependent due to marriage, birth, adoption or placement of adoption; 32-Marriage, 02-Birth, 05-Adoption, located in the INS04 – Maintenance Reason Code. (3) An individual, who was not previously a citizen, national or lawfully present individual gain such status; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (4) A QI enrollment or non-enrollment in a QHP is the result of an Exchange ERROR; EXCHANGE ERROR, located in the 2750 as SEP REASON. (5) Qualified Health Plan (QHP) is in violation of material provision of its contract with the enrollee; AB/Dissatisfied with medical care/service rendered, located in the INS04-Maintenance Reason Code.			

Category	Question	Answer	FAQ Title	Agency	Site
		(6) Newly eligible for Advance Premium Tax Credit (APTC) or change in Cost Sharing Reduction (CSR); FINANCIAL CHANGE, located in the 2750 as SEP REASON. (7) New QHPs available due to a permanent move; 43-Change of Location, located in the INS04-Maintenance Reason Code. (8) Indian; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (9) Exceptional Circumstances; EXCEPTIONAL CIRCUMSTANCES, located in the 2750 as SEP REASON.			
Enrollment & Transaction	**Q15:** Does the payment transaction ID (2000, REF02 where REF01 = 6O) need to be sent back on the 834 confirmation file?	**A15:** Yes. In Section 10.2 Enrollment Confirmation/Effectuation Instructions, titled: "QHP Issuer to FFE," the Companion Guide states: Except where overruled by the usage requirements of the 005010X220 TR3, QHP Issuers must return all the information transmitted on the Initial Enrollment Transaction in addition to the information detailed below."	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q16:** Policy Number - Issuers are to send the enrollee's policy number back to the Federally-facilitated Marketplace (FFM). How will the FFM use the policy number (an identifier, customer	**A16:** The term for policy number in the ASC X12 834 Implementation guide has the same meaning as the Issuer assigned health coverage purchased policy number, and is the same as the Issuer Assigned Policy number. This identifier will be returned to the issuer on subsequent transactions where appropriate, and it will also be used in Monthly IRS reporting when required.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

Category	Question	Answer	FAQ Title	Agency	Site
	service, etc.)? This pertains to loop 2300, REF02 Member Group or Policy Number - Issuer assigned health coverage purchased policy number. The identifier is required on Confirmation Transactions. It is different than loop 2000 REF02 Member Supplemental Identifier which is the issuer assigned subscriber ID.	The Federally-facilitated Marketplace (FFM) is considering use of the issuer's assigned enrollee's policy number during reconciliation processing If the issuer uses the policy number as the Subscriber Number, it should be included in both member identifier data elements of the 834.			
Enrollment & Transaction	**Q17:** Employer Paid Amount: Is the employer paid amount a dollar amount or a percentage? Or can it be one or the other? If it can be one or the other, how is that designated on the 834 file?	**A17:** The employer paid amount or employer responsibility amount is a dollar amount. Details about this field can be found in Section 9.6.2 SHOP Market: 2750 Member Reporting Categories Loop, Table 14. In the ASC X12 834 enrollment transaction, the SHOP Member Reporting Category Loop lists the format of the employer paid amount as: NNNNNNNN.NN	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf
Enrollment & Transaction	**Q18:** In the March 27, 2013 webinar	**A18:** This data element will be included in the next version of the Companion	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

Category	Question	Answer	FAQ Title	Agency	Site
	called "Enrollment in the Federally Facilitated-SHOP Market webinar, a new value is being sent in the 2750 loop - REQUEST SUBMIT TIMESTAMP. This value is not mentioned in the CMS/FFE Companion Guide. What does this value represent? Should it be returned on the ASC X12 834 confirmations? If yes, should it be the same date/time as received on the inbound 834 to the carrier?	Guide. It is the [REQUEST SUBMIT TIMESTAMP] – CurrentTimeStamp. This timestamp is captured at the time the Application Filer selects and presses the "CONFIRM" button on their enrollment choice. The timestamp was added to help maintain the correct order of transactions in daily files.			
Enrollment & Transaction	**Q19:** We understand the Exchange will send the National Producer Number (NPN) if available. However, since the Navigator and Broker use the same field on the application, will the Federally-facilitated	**A19:** The enrollment transaction will only carry the broker information in the N1 Segment, Loop 1000C; the Federally-facilitated Marketplace will not send information for the Navigators, as this information was not mapped for the 834 transaction.	FAQ July 3, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_070313.pdf

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	Marketplace (FFM) only send the NPN or is it possible that Issuers will receive a code and information for brokers and a code and information for navigators in the same position?				
Policy and Technical Information	**Q1:** What time of day will the ASC X12 834 transaction files be transmitted to Issuers?	**A1:** The Federally-facilitated Marketplace has not finalized the decision about daily transmission times yet.	FAQ July 2, 2013	CMS	**GET LINK (1-22)**
Policy and Technical Information	**Q2:** The 834 Enrollment Companion Guide has only one field for Agent ID, but it looks like an agent can log into the Federally-facilitated Marketplace (FFM) with both the Marketplace Assigned ID and/or the National Producer Number (NPN). We need to confirm that this is the case if Issuers are to receive both	**A2:** The Federally-facilitated Marketplace will send only one identifying number for the Broker or Agent on the ASC X12 834 Enrollment transaction, using the number that the individual has used to log in to the system. That number could be either the Marketplace Assigned ID or the National Producer Number (NPN). Within the information model CMS has designed, the enrollment transaction will only provide the one number. It is possible for an issuer to receive both the Broker and an Agent on one transaction, each with one NPN or one Marketplace ID as the identifier.	FAQ July 2, 2013	CMS	

Category	Question	Answer	FAQ Title	Agency	Site
	identifiers on the 834 transaction?				
Policy and Technical Information	**Q3:** Are there values/definitions for the Special Enrollment Period (SEP) Reason Codes?	**A3:** Within the ASC X12 834 enrollment transaction, every effort is being made to use existing Maintenance Reason Codes (INS04) where applicable. In those instance where there is not an existing maintenance reason code that describes the Special Enrollment Reason, the FFM will include a loop in the 2750 "SEP REASON" and add a proprietary code. The SEP Reason codes are as follows: (1) Qualified Individual (QI) or dependent loss of Minimum Essential Coverage (MEC); 07-Termination of Benefits, located in the INS04-Maintenance Reason Code. (2) QI gains or becomes a dependent due to marriage, birth, adoption or placement of adoption; 32-Marriage, 02-Birth, 05-Adoption, located in the INS04 – Maintenance Reason Code. (3) An individual, who was not previously a citizen, national or lawfully present individual gain such status; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (4) A QI enrollment or non-enrollment in a QHP is the result of an Exchange ERROR; EXCHANGE ERROR, located in the 2750 as SEP REASON. (5) Qualified Health Plan (QHP) is in violation of material provision of its	FAQ July 2, 2013	CMS	

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		contract with the enrollee; AB/Dissatisfied with medical care/service rendered, located in the INS04-Maintenance Reason Code. (6) Newly eligible for Advance Premium Tax Credit (APTC) or change in Cost Sharing Reduction (CSR); FINANCIAL CHANGE, located in the 2750 as SEP REASON. (7) New QHPs available due to a permanent move; 43-Change of Location, located in the INS04-Maintenance Reason Code. (8) Indian; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (9) Exceptional Circumstances; EXCEPTIONAL CIRCUMSTANCES, located in the 2750 as SEP REASON.			
Policy and Technical Information	**Q4:** In the ASC X12 834 Enrollment Transaction, is the ISA06 Sender ID the same as the Source Exchange ID in Loop 2750 REF02?	**A4:** Yes, both identifiers will be the source exchange ID (identifier).	FAQ July 2, 2013	CMS	
Policy and Technical Information	**Q5:** In the Enrollment Transaction, is the 1000A N101 Plan Sponsor the alternate payer?	**A5:** In the Federally-facilitated Marketplace, the subscriber is listed in 1000A. In the FF-SHOP, the Plan Sponsor is the employer group. We do not use the term alternate payer in the FFM.	FAQ July 2, 2013	CMS	
Policy and Technical	**Q6:** In the	**A6:** The Federally-facilitated	FAQ July 2,	CMS	

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Category	Question	Answer	FAQ Title	Agency	Site
Information	Enrollment Transaction, in the field for 1000B N102 Payer, what information is published as the name?	Marketplace will insert the name of the issuer that was provided in HIOS for the Qualified Health Plan (QHP) application.	2013		
Policy and Technical Information	**Q7:** Does the 2320 Coordination of Benefits need to be included on the Issuer to Federally-facilitated Marketplace (FFM) 834 file?	**A7:** No, the Federally-facilitated Marketplace is not sending Coordination of Benefits information to the Issuers, so there is no expectation for this information to be returned by the issuer to the FFM.	FAQ July 2, 2013	CMS	
Policy and Technical Information	**Q8:** Are the 2100G, 2100F Loops for Responsible Person and Custodial Parent required on the Issuer to FFM ASC X12 834 Enrollment file?	**A8:** On daily files, the Federally-facilitated Marketplace (FFM) is requesting that Issuers return all of the data the FFM sent in the initial enrollment transaction, along with the new issuer assigned member identifier, issuer policy number etc. This does not apply to the monthly audit files for which separate instructions will be provided.	FAQ July 2, 2013	CMS	
Policy and Technical Information	**Q9:** What is the format/definition of rating areas to be used on the ASC X12 834?	**A9:** The ASC X12 834 enrollment transaction will include the address for the enrollee and a location identifier for that address within its county. The format of the location identifier is 5 digits, alphanumeric. The first two	FAQ July 2, 2013	CMS	

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		characters are the state abbreviation followed by 3 digits which identify the county based on the FIPS data base. For example, a county in Arizona would appear as: AZ123. Additional information is provided in the Companion Guide, which is available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf.			
Policy and Technical Information	**Q10:** On the 834 audit file, how will historical data be structured in comparison to current data? Should the records be sent in a particular order?	**A10:** Details about the requirements and structure of the monthly reconciliation audit file and how the records should be sent will be finalized by the end of July.	FAQ July 2, 2013	CMS	
Policy and Technical Information	**Q11:** Where will adjustment reason codes be found on the HIX 820 premium payment report transaction?	**A11:** The HIX 820 premium payment report transaction does not have a data field for adjustment reason codes. The Centers for Medicare & Medicaid Services (CMS) plans to issue a monthly payment letter that will outline key adjustments made during the monthly payment cycle. The 2300 Loop REF03 “Exchange-Related Report Type” element will provide report reference numbers. These referenced documents will provide additional	FAQ July 2, 2013	CMS	

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		information on manual adjustments. The format and method of distribution for these documents are still being evaluated and will be provided later in 2013.			
Policy and Technical Information	**Q12:** The Exchange Final Rule requires that a QHP issuer provide notice to an enrollee if coverage is terminated at least 30 days prior to the last day of coverage and notify the Exchange of the effective date of termination and reason. We have not yet received written clarification on who will be responsible for rolling the over-age dependent off the policy, and who will provide notice to the individual. Please confirm the following for the FFM: a. Health plans will complete the termination and provide notice to the aged-off dependent	**A12:** The process for handling aging-off dependents is still under development. We are currently engaged in dialog with Issuers and we anticipate finalizing the policy and process by the end of July.	FAQ July 2, 2013	CMS	

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	and primary subscriber in a manner consistent with the Exchange Regulations and applicable state laws. CMS will be providing additional guidance on these processes in the near future. b. Following the FFM's receipt of the termination from the Issuer, an exchange eligibility determination will be triggered by the FFM to examine impact on premium, ATPC amount and CSR eligibility as a result of the enrollment change. c. The FFM is developing additional eligibility support and outreach approaches to ensure the consumer's eligibility and enrollment information remain				

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	update date. d. For initial enrollments, the FFM is currently not programming to state specific rules like full-time student or veteran's status).				
Policy and Technical Information	**Q13:** Enrollment File Indicator: States that permit coverage of dependents over age 26 may do so only for certain adult children, including veterans, full-time students, or persons with disabilities. The Federally-facilitated Marketplace does not obtain or provide this information as part of the eligibility determination process. However, health plans need a way to provide the reason for termination to the Marketplace. For example, in Iowa (a State Partnership Exchange), Issuers must allow	**A13:** The Federally-facilitated Marketplace will add several codes to the list of maintenance reason codes for communicating termination reasons to the Issuers, including codes for fraud, non-payment of premium and minimum essential coverage. These codes will be listed in the next version of the Enrollment Companion Guide, expected to be published by mid-August. In addition, the testing process, which begins July 15th, is expected to generate additional information that will result in another version of the Companion Guide before October 1, 2013. CMS is discussing methods for providing disability status to Issuers based on relationship codes used on the application forms.	FAQ July 2, 2013	CMS	

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	dependents to maintain their parent's coverage if the child is a full-time student or has a disability. Will CMS be updating a list of termination reason codes to account for terminations other than non-payment of premium? If so, when? Currently the companion guide indicates that the disability indicator will not be sent on the 834? Will CMS consider revising the companion guide as this impacts whether individuals can remain on the policy after the maximum dependent age?				
Policy and Technical Information	**Q14:** Aging off Pediatric Coverage: What will occur when an individual is enrolled in pediatric dental and they reach the age when Dental Pediatric coverage will end? Will the	**A14:** CMS is developing a process to address the topic of "dependent age out," issuer options for action, and roles for the FFM and the Issuers. Information should be available by the end of July.	FAQ July 2, 2013	CMS	

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	FFM manage the eligibility and send the issuer a termination 834 Transaction at the end of the plan year after the individual meets the age limit for pediatric dental coverage (e.g. 19 years)? If the FFM does not send a termination transaction, then the individual will still be enrolled in the issuer's system because the issuer cannot terminate individuals. The policies for "dependent age out" on a family plan vary by State. If the family does not take any action during open enrollment (i.e., wants to maintain current coverage), will the FFM be able to determine that the dependent is no longer eligible based on the age? If the FFM does not enroll				

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	an over age dependent, will it send a termination transaction, or just send an updated enrollment transaction for the entire family/enrollment group?				
Policy and Technical Information	**Q15:** Policy Number: Issuers are to send the issuer's assigned enrollee's policy number back to the Federally-facilitated Marketplace (FFM) in the confirmation transaction. Specifically, this is referring to loop 2300, REF02 Member Group or Policy Number - Issuer assigned health coverage purchased policy number. How will the FFM use this policy number (an identifier, customer service, etc.) which is different than loop 2000 REF02	**A15:** The Federally-facilitated Marketplace (FFM) will use the issuer's assigned enrollee's policy number as one of multiple data elements to ensure an accurate enrollee match during reconciliation processing. There are also IRS reporting requirements for Issuers, and the FFM is considering sending the issuer's assigned identifiers to the IRS.	FAQ July 2, 2013	CMS	

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	Member Supplemental Identifier (the issuer assigned subscriber ID)?				
Policy and Technical Information	**Q16:** 834 Confirmations for Enrollment Changes. This requirement is not in the ASC X12 834 Companion Guide but was mentioned in the annual letter to Issuers: chapter 5, SECTION 4. TRANSMISSION OF ENROLLMENT INFORMATION BETWEEN THE FFE AND QUALIFIED HEALTH PLANS, subsection ii: The letter also states that "in response to the exchange sending a file to an issuer containing changes for multiple enrollees, once the issuer has made those changes or effectuated an	**A16:** The Federally-facilitated Marketplace does not require Issuers to send a confirmation transaction for changes. We will clarify this in the next version of the Enrollment Companion Guide as well as any future versions of the Issuer Letter/Annual Letter.	FAQ July 2, 2013	CMS	

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	enrollment, the issuer will send the exchange a full ASC X12 834 "confirmation" record for each individual affected". This requirement is not in the ASC X12 834 companion guide and does not have an "issuer to FFE" transaction for "changes". We do not recommend confirmations for enrollment changes because it would create an unnecessary amount of files.				
Policy and Technical Information	**Q17:** Will CMS provide a machine-readable EDI implementation guideline for their particular implementation (SEF, for example), and if so, what standards / format(s) will be available?	**A17:** CMS is not planning to provide a machine-readable EDI implementation guideline for the implementation of any programming for the Federally-facilitated Marketplace.	FAQ July 2, 2013	CMS	

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Policy and Technical Information	**Q18:** In one of the enrollment scenarios (#8), it talks about multiple tax filers who both qualify for APTC and CSR, and each of them have a child. The life partner has one child and is listed as the responsible person for that child. Will the APTC and CSR amounts be combined and placed under the subscriber in this scenario?	**A18:** Yes. If both partners are eligible for APTC, the amounts will be combined and placed under the subscriber in this scenario.	FAQ July 2, 2013	CMS	
Policy and Technical Information	**Q19:** Will the Federally-facilitated Marketplace Assigned ID for brokers be sent on the ASC X12 834 enrollment transaction along with the broker's National Producer Number (NPN)? If yes, is the FFM ID going to be sent when the broker is using the FFM	**A19:** The Federally-facilitated Marketplace will send one identifier for the broker, either the Marketplace Assigned ID or the National Producer Number, depending on which identifier the broker used to log in to the system. When the broker provides side by side assistance to the enrollee, the identifier they use to log in to the system will be the identifier sent on the enrollment transaction.	FAQ July 2, 2013	CMS	

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	(sitting side by side with consumer) and they enter their NPN?				
Policy and Technical Information	**Q20:** When would a program level manual adjustment (APTC MADJ) be made? Is this only during reconciliation? Shouldn't adjustments always be tied to a subscriber?	**A20:** During the monthly payment approval process, CMS will perform a series of analytical checks to help identify any payment issues. These issues may be the result of improper system programming, bad data transfers from one system to another, rounding errors, file integrity issues, etc. A manual adjustment may take place when CMS has identified a payment issue through these reviews. For example, an APTC Manual Adjustment (APTCMADJ) may occur when CMS is aware of an error in enrollment group data that has not yet been resolved. Due to a system error, an issuer cannot provide enrollment-related data to CMS. While the error is being resolved, CMS may choose to issue an APTC Manual Adjustment similar to a previous month's APTC payment amount. This results in a manual adjustment amount being sent to the payee because enrollment group information is not yet available. When accurate enrollment group data becomes available, CMS can then correct the payment made using the updated information.	FAQ July 2, 2013	CMS	
Policy and Technical	**Q21:** For the	**A21:** We will send the member mailing	FAQ July 2,	CMS	

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Information	member, will the 2100C loop or other address loops be sent to indicate the member's mailing address or will you send only 2100A loop for address?	address in the 2100C loop if applicable. The ASC X12 834 Implementation Guide (TR3) requires that the mailing address be sent if it is different from the residential address (in 2100A) or when the dependent's address is different from the Subscriber's address. The FFM will send the mailing address when these situations apply.	2013		
Policy and Technical Information	**Q22:** The ASC X12 834 Enrollment Companion Guide indicates that Issuers need to provide back to the FFM the same information on the effectuation file as was passed to them on the ASC X12 834 enrollment inbound. However, Issuers may not necessarily store information sent on the file. Furthermore, there will be some codes that we would not be able to map back to the code that came in on the file. Will CMS expect to receive the exact codes that came in on the enrollment file in the effectuation and	**A22:** Yes, CMS expects the same codes that came in on the enrollment file to be returned on the effectuation and reconciliation files. With respect to a policy codes that are irreversible – Adopted child mapped to Dependent and back to Adopted Child – CMS will have further discussions with Issuers about this topic to determine this best options.	FAQ July 2, 2013	CMS	

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	reconciliation files? Can CMS provide a policy on which relationship codes are irreversible (meaning, they need the same code that they sent in the 834 enrollment to the carrier)? One example: Relationship codes have many possible values based on the TR3 that may be mapped to a shortened list on the carrier side. "Sister-in-law", "Adopted Child" and many others may all be mapped to "Dependent" in carrier system. Will CMS require Issuers to reverse map back "Dependent" into "Sister-in-law" and "Adopted Child" and all others possible?				
Affordable Care Act Fees	Question #62: When may an issuer exclude Affordable Care Act fees, such as those required by	Answer #62: Issuers may exclude ACA assessments or fees from MLR calculations for a reporting year only if such assessments or fees were incurred in that reporting year. Issuers may not	**TITLE?**	CMS	http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mlr-guidance-7-02-2013.pdf

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	ACA §9010, from premium in its MLR and rebate calculations?	exclude ACA assessments or fees they expect to incur in future MLR reporting years. Specifically, an issuer may not report such amounts as assessments and fees described in 45 CFR §158.161(a) and §158.162(a)(1) and (b)(1), or as unearned premium described in 45 CFR §158.130(b)(4). As discussed in the HHS Notice of Benefit and Payment Parameters for 2014, published on March 11, 2013, "PHS Act section 2718 does not provide for estimated regulatory fees for future years to be deducted from premium used in MLR and rebate calculations for the reporting year." 78 FR 15410 at 15505-15506.			
Enrollment & Transaction Frequently Asked Questions	**Q1:** The April 2013 Annual Letter to Issuers indicated that Issuers must notify providers that may be affected by an enrollee entering a grace period for non-payment (providers who submit claims for services they have provided to individuals during the grace period and for which they risk not being reimbursed). When should the QHP Issuer send the notice	**A1:** CMS does not intend to regulate on the timing or detailed procedures for the grace period notifications to providers. However, we are developing guidance regarding timing and content for this provider notification, as well as and recommendations for communication about claims processing or claim status for an enrollee in the three month grace period.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf

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	to providers? Should it be sent as soon as the enrollee enters the grace period or in response to a submitted claim? If the latter, does notice need to be re-issued for each claim submitted by a single provider? Does the notice need to be sent at some regular interval (i.e., each month of the grace period?				
Enrollment & Transaction Frequently Asked Questions	**Q2:** As per 45 CFR 156.270(d)(2), when someone who receives APTC has fallen into the delinquency grace period, the Issuer must "notify Health and Human Services (HHS) of such non-payment." The regulation does not specify the means by which the Issuer is to provide the notification to HHS, but some Issuers would like to send	**A2:** If an enrollee fails to *pay in full* his or her portion of any premium due prior to the end of the applicable grace period, QHP Issuers must send an 834 termination transaction to the Marketplace. In addition, Issuers must participate in a reconciliation process with the Federally-facilitated Marketplace (FFM). Each month, Issuers will submit a reconciliation audit file with certain data elements for every current enrollee, including the "premium paid through date." This will identify the FFM enrollees who are in a payment delinquency status, thus meeting the notification requirement for non-paying enrollees.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf

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	the termination transaction to the Federally-facilitated Marketplace (FFM) at the conclusion of the grace period. Is this permissible?				
Enrollment & Transaction Frequently Asked Questions	**Q3:** In the April, 2013 Letter to Issuers there is mention that "…the QHP Issuer must report current and accurate information on the status of qualified individual and enrollee premium payments." The letter says: "QHP Issuers will provide up-to-date information on the last premium payment date for every enrollee." How are QHP Issuers to report this information?	**A3:** Issuers must participate in a reconciliation process with the Federally-facilitated Marketplace (FFM). In the monthly reconciliation audit file, Issuers will submit the "premium paid through date" for every current enrollee. This will identify for the FFM, enrollees who are in a payment delinquency status, thus meeting the notification requirement for non-paying enrollees.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf
Enrollment & Transaction Frequently Asked Questions	**Q4:** In the final Exchange Rule, the provision at §156.270(b)(1)	**A4:** On July 15, 2013, CMS published the Eligibility and Enrollment Final rule (CMS-2334-F), which streamlines a number of provisions in the Affordable	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf

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	requires that a QHP Issuer provide an enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage. Does the date of the notice dictate the date of termination, or does the notice simply give 30 days for the enrollee to make the payment? Which of the following scenarios would be in compliance with the above? *Scenario 1: Premium payment for the month of March is due 3/1; enrollee does not pay by 3/31. Health Plan sends a termination of coverage notice to the enrollee on April 1st. Member does not pay premium. Health Plan terminates the enrollee effective*	Care Act, including those related to termination. In this Final rule, the termination of coverage notice provision at §156.270(b) states if the QHP Issuer terminates an enrollee's coverage in accordance with §155.430(b)(1)(i), (ii), or (iii), the Issuer must, "promptly and without undue delay: (1) Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination. " This regulatory clarification does not alter the rules for the effective date of termination for non-payment of premium. For enrollees receiving APTC, termination will continue to be the last day of the first month of the three month grace period. For enrollees not receiving APTC, the effective date of termination must be in accordance with the standard policy established by the QHP Issuer in accordance with §156.270(c).			

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	2/28. 2: As above, enrollee does not pay premium for month of March. Health Plan sends a termination of coverage notice to the enrollee on April 1st. Member does not pay premium. Health Plan terminates the enrollee effective 4/30.				
Enrollment & Transaction Frequently Asked Questions	**Q5:** According to the CMS Enrollment Companion Guide, three possible qualifiers for 2100G (Responsible Person Loop) are: 1) E1 Person or Other Entity Legally Responsible for a Child (QMCSO), 2) QD Responsible Person, and 3) S1 Parent. However, per the ASC X12 834 Implementation Guide, Power of Attorney should have a qualifier J6. What qualifier will be sent in 2100G for Power of Attorney data?	**A5:** The CMS Enrollment Companion Guide explicitly uses only two of the 13 available qualifier codes from the ASC X12 834 Implementation Guide for use in the 2100G Segment. These two qualifiers are: QD for Responsible Person and S1 for Parent. These are the only two codes CMS plans to use in the Federally-facilitated Marketplace. If QHP Issuers feel that other qualifier codes such as Power of Attorney are necessary, recommendations may be submitted to Comments834guide@cms.hhs.gov. The policy and technical team at CCIIO will consider the requests for future development schedules.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf

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Enrollment & Transaction Frequently Asked Questions	**Q6:** Race and Ethnicity questions are asked separately, as two distinct questions on the Federally-facilitated Marketplace (FFM) enrollment application, but there is only one field in ASC X12 834 Enrollment transaction to represent both data elements (DMG05-01 in 2100A). What are the rules to combine the race/ethnicity into one data element? (AHIP 65)	**A6:** Federal law sees race and ethnicity as distinct, and that is why there are two separate questions on the Federally-facilitated Marketplace application. The ASC X12 834 Implementation Guide provides a situational field for race *or* ethnicity, with the notation that the data "is normally self-reported and under certain circumstances is collected for United States Government statistical purposes." There are no other rules or regulatory guidance beyond the constraints of the ASC X12 834 Implementation Guide.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf
Enrollment & Transaction Frequently Asked Questions	**Q7:** An individual is eligible and takes Advance Premium Tax Credit (APTC) on his medical QHP plan. However, there is not enough APTC to also apply to their dental plan. CCIIO indicated on a 6/17 enrollment technical	**A7:** Consistent with the policy regarding Advance Premium Tax Credit (APTC) and eligibility for the grace period for individuals on a standard medical plan, if no APTC is applied to the dental plan, the enrollee would not be eligible to receive a grace period for three consecutive months for that (dental) plan.	FAQ July 22, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ6_5CR_072213.pdf

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	call that that the enrollee would still be considered an APTC recipient and the 90 day grace period would apply to the dental plan. However, since the indicator on the dental plan would reflect $0, how would the dental plan know the enrollee is APTC eligible to give them the 90 day grace on the dental plan, particularly if an individual has medical coverage with one Issuer and dental coverage with a Stand Alone Dental Plan?				
Quality Health Plan Webinar Series: Plan Preview	**Q1:** What is the Plan Preview period?	**A1:** Plan Preview will be conducted in August during which issuers in SPMs and FFMs will be able to log into HIOS and review a selection of their submitted issuer and plan data. The data that will be displayed during plan preview will represent all of the issuer's submitted plans, not necessarily those that will be certified as QHPs. Issuers will be able to communicate any data errors to CMS and will then have an opportunity to	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		correct certain data within a specified timeframe.			
Quality Health Plan Webinar Series: Plan Preview	**Q2:** When is Plan Preview?	**A2:** Plan Preview will begin on August 8, 2013. Issuers should plan to submit all requests to make changes to QHP data by August 16th and to make any necessary data submissions with adjusted QHP data templates by August 23rd.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Plan Preview	**Q3:** When can issuers view or change their accreditation information?	**A3:** QHP issuers will be able to review their accreditation status and CAHPS data between August 19th and August 23rd. Issuers will be asked to submit requests for updates/corrections to accreditation data as rapidly as possible after August 19th. Issuers that have received a new accreditation from NCQA or URAC may update their applications during Plan Preview from August 8th to August 23rd.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Plan Preview	**Q4:** If an issuer submitted its QHP data through SERFF, will it be able to review its data during Plan Preview?	**A4:** Yes. Plan Preview is for all issuers in Federally-facilitated Marketplaces (FFM) and State Partnership Marketplaces (SPM). Issuers that submitted QHP Applications in SERFF will be able to view their plan data in Plan Preview in the HIOS system. If an FFM issuer was asked by its state to submit a separate QHP application submission in SERFF, these data will not be transferred to HIOS. The data that will be displayed for Plan Preview for these states will be the data that were submitted into HIOS.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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Quality Health Plan Webinar Series: Plan Preview	**Q5:** How can an issuer access the Plan Preview module in HIOS?	**A5:** Issuers in FFM and SPM states must have Validator user roles in HIOS. Issuers that do not already have HIOS User IDs should follow the instructions in the HIOS User Guide (located at the link below) to request a HIOS User ID. The issuer will need to request a Validator role for at least one of the following three QHP modules in HIOS: the QHP Issuer Module; the QHP Benefits & Service Area Module; or the QHP Rating Module. The link to the HIOS User Guide is: http://www.cms.gov/CCIIO/Resources/Files/Downloads/portal_user_manual_032013.pdf.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Plan Preview	**Q6:** What will be the process for Plan Preview of OPM Multi-State Plans (MSPs)?	**A6:** OPM MSPs will be on a slightly later timeline than QHPs. CMS is working with OPM to define the process and timeline for Plan Preview for MSPs.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Information Displayed During Plan Preview	**Q7:** What data can issuers check and validate during Plan Preview?	**A7:** Issuers will be able to view the following three pages during the Plan Preview period: the Plan Preview Summary page, the Rating Scenarios page, and the Plan Details page. The Plan Preview Summary and Rating Scenarios pages will provide the issuer with the opportunity to view their list of submitted plans and to select a plan, a rating scenario, and a zip code in order to populate a Plan Details page. The Plan Details page displays plan	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		information in a manner similar to the Consumer Portal. This information includes the calculated premium for the plan according to the selected rating scenario, other cost information such as the deductible and out-of-pocket maximum for the plan, and selected cost-sharing information for certain benefits.			
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q8:** What is the process for making a change to QHP data in the QHP Application submission?	**A8:** Issuers that wish to make changes to their QHP data templates based on the display in Plan Preview should submit a request to the XOSC Helpdesk. The XOSC Help Desk may be contacted via email at CMS_FEPS@cms.hhs.gov or via phone at 1-855-CMS-1515. CMS encourages issuers to consolidate the changes they would like to make in as few communications to the Help Desk as possible. All corrections except rate corrections can be grouped in a single communication. Rate corrections can be grouped together in a second communication. However, to the extent that an issuer identifies problems with the premium calculations displayed in Plan Preview, CMS encourages the issuer to first work through any additional rating scenarios and plans that they have not yet tested and then contact CMS via the Help Desk as soon as possible. When contacting the Help Desk, issuers should include the following information: Subject Line: "Request to Change QHP Data for	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		Issuer (HIOS ID)" A. HIOS Application ID B. HIOS Issuer ID C. Issuer Name D. Issuer State E. Impacted Plan ID (and variant if applicable) F. Screenshot highlighting where the problem exists (if sending an email) G. Notation of the inputs selected in the rating scenarios if identifying a premium calculation error H. Description of the change(s) requested and as much description as possible of the error or problem identified I. Justification if changing the Plan & Benefits, Business rules, or Rating Table Template(s)			
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q9:** What QHP data can Issuers request to change during Plan Preview?	**A9:** Issuers will only be allowed to change data that do not trigger a re-review of the issuer's QHP Application. Issuers may not change any data during Plan Preview without the explicit and specific approval of CMS. To assist issuers in preparing for Plan Preview and for submitting requests for data changes, below is a draft list of data changes that CMS will likely approve. However, even if a data element appears on this list, all issuers must submit a formal request and obtain CMS approval before altering the QHP Application. To the extent that issuers wish to change additional data, these requests should also be routed through the same process. However, CMS is unlikely to approve significant data changes beyond the list below. Requests for changes that CMS expects to	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		approve include changes to: • Issuer Marketing Name • Plan Marketing Name • Network URL • Formulary URL • Plan Brochure URL • SBC URL • Enrollment Payment URL • Certain fields on Plans & Benefits Template: o Is a referral required for a specialist? o Specialist requiring a referral o Benefit-Level Exclusions (deletions permitted; revisions must be substantively equal to original) o Benefit-Level Explanations (deletions permitted; revisions must be substantively equal to original) o Wellness Program Offered o Disease Management Program Offered • Issuer business rules • Issuer rating tables (only changes not impacting the URRT will be allowed) • Accreditation status and other fields in the Accreditation Template			
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q10:** How will an issuer know whether a request for change has been approved?	**A10:** CMS will review each request to change QHP data, and consult with the state if applicable. After a determination is made, issuers will receive a response to their help desk tickets. Some issues will be resolved more quickly than others depending on complexity.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q11:** How do issuers make approved changes?	**A11:** Issuers that originally submitted their applications in HIOS should log into HIOS and make the necessary corrections to the application templates. Issuers that originally submitted their applications in SERFF will submit their changes into SERFF. CMS will work with each state to approve requests for changes, and states may be reaching out to issuers related to these requests.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q12:** How will an issuer confirm that changes have been processed and uploaded?	**A12:** For changes submitted into HIOS, most changes will be processed by the system within approximately 24 hours and appear on Plan Preview the next day; however, in some instances this may take more time. Changes submitted into SERFF will likely take slightly longer to appear in HIOS. Issuers should check HIOS to verify their new data before the end of Plan Preview on August 23rd. Issuers may not be able to confirm updates/corrections to accreditation data due to the need to verify this data with NCQA and/or URAC.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q13:** How will states be involved in the Plan Preview process?	**A13:** CMS will involve the state in approving or disapproving requests for data changes submitted by issuers to the extent desired by the state. SPM states will also need to communicate with issuers about making changes in SERFF associated with approved requests for changes. Finally, states will need to send only revised plans in SERFF to	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		HIOS so the revised data can be viewed in Plan Preview.			
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q14:** What is the process for updating an Issuer Marketing Name?	**A14:** The issuer will need to utilize the existing HIOS web edit feature to make changes to its Issuer Marketing Name. Issuers wishing to make this change will need to take the following steps: 1. Login to HIOS 2. Navigate to the Plan Finder (PF) module listed under HIOS Functions 3. Select the 'View Issuer Submitted Data' tab a. Select the 'Issuer General Information' link 4. Using the dropdown, select the Issuer requiring the Marketing Name update 5. Under the 'Issuer General Information for Issuer: <previously selected Issuers name> select 'Edit Issuer General Information' 6. The Issuer Marketing Name is the second data element from the top in the right hand column 7. After making the desired change scroll to the bottom of the page a. Select the 'Submit' button 8. The change is then committed to the database and seen on the screen The Issuer Marketing Name does not need to be changed in the Administrative Template unless the issuer wishes to change other data elements in this template. If the issuer wishes to change other data in the Administrative Template, the issuer will first need to make the change to the Issuer Marketing Name in the HIOS web edit feature and then download a new version of the Administrative	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf

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		Template with the revised Issuer Marketing Name prepopulated in the template. Then the template can be resubmitted into the QHP Issuer Module.			
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q15:** Can issuers change rates during Plan Preview?	**A15:** Issuers may make corrections to the rating template or to the business rules template, but any such corrections must not impact an issuer's rates as submitted on the Unified Rate Review Template and approved by the applicable regulator (e.g., the state department of insurance). Any corrections to rating tables or business rules must be approved or requested by the applicable review authority.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Quality Health Plan Webinar Series: Process for Requesting Changes to QHP Data Displayed on Plan Preview	**Q16:** Do QHP issuers need to provide a URL for the Summary of Benefits and Coverage (SBC) during plan preview?	**A16:** Yes, if a QHP issuer has not already provided a URL for the SBC, an issuer must include the URL during plan preview. As noted in Chapter 10: Instructions for the Plans & Benefits Application Section, while this was identified as an optional field, issuers are required to submit it prior to open enrollment. SADP issuers are not required to provide a URL for the SBC.	FAQ July 29, 2013	CMS	https://www.regtap.info/uploads/library/PM_QHP_FAQ13_072913_5CR_072913.pdf
Federally-facilitated Marketplace for SHOP: Group Termination for Non-payment of Premium	**Q1:** How will an issuer communicate to the FF-SHOP that a group should be terminated for non-payment of premium?	**A1:** An issuer will notify the FF-SHOP that a group has been terminated due to non-payment of premium through an 834 cancellation transaction.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated	**Q2:** Will minimum	**A2:** Yes, minimum participation rate	FAQ July 30,	CMS	https://www.regtap.info/uploads/library/

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Marketplace for SHOP: Minimum Participation Rates	participation rates take into account employees who have coverage elsewhere?	calculations will take into account employees that have coverage elsewhere. Generally, employees with other group coverage (e.g., from a spouse, and those with public coverage, such as Medicare or Medicaid) will be excluded from minimum participation rate calculations. Employees with individual coverage, including Individual Marketplace coverage, will be included in minimum participation rate calculations. See 45 C.F.R. §155.705(b)(10) of the HHS Notice of Benefit and Payment Parameters for 2014 for additional information on how minimum participation rates will be calculated in the FF-SHOPs. (http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=ae144e1dcb4c7a762b3139efbc1e39ff&ty=HTML&h=L&r=PART&n=45y1.0.1.2.70#45:1.0.1.2.70.8.27.2).	2013		SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Minimum Participation Rates	**Q3:** Does the FF-SHOP minimum participation requirement apply to stand-alone dental coverage?	**A3:** No, the minimum participation rate provision in 45 C.F.R. §155.705(b)(10) applies only to comprehensive medical QHPs offered through the FF-SHOPs. CMS does not intend for the FF-SHOP minimum participation requirements to apply to stand-alone dental coverage. Many of the adverse risk segmentation concerns that exist for medical plans do not apply to stand-alone dental plans. Unlike medical QHPs in the FF-SHOP, dental plan issuers may continue to adjust premiums to reflect risk when	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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		pricing plans in the FF-SHOP by redirecting employers to dental plan issuer sites for quoting and enrollment purposes.			
Federally-facilitated Marketplace for SHOP: Minimum Participation Rates	**Q4:** Previously, it was mentioned that state minimum participation rates would be adhered to if a state's rate was higher than the FF-SHOP's default 70% rate. Is that still accurate or will all states participating in the FF-SHOP be required to adhere to the 70% participation rate?	**A4:** Pursuant to 45 C.F.R. §155.705(b)(10), states participating in the FF-SHOP must follow the 70% minimum participation rate rule. However, if a State can provide evidence to CMS that either State law or wide-spread issuer practice dictates a rate higher or lower than the FF-SHOP's default rate, that State rate may be used in place of the 70% participation rate requirement. Based on information received to date from States, FF-SHOPs will use different minimum participation rates in the following States for 2014: **State (FF-SHOP Min. Part. Rate)** Arkansas (75%) Iowa (75%) New Hampshire (75%) New Jersey (75%) South Dakota (75%) Tennessee (50%) Texas (75%)	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Minimum Contribution Requirements	**Q5:** Will there be any contribution requirements for small groups that participate in the FF-	**A5:** No, minimum contribution rates will not apply in the FF-SHOP. In addition, issuers will not have the ability to impose minimum contribution rates for groups participating in the FF-	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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	SHOP?	SHOP.			
Federally-facilitated Marketplace for SHOP: Late Payment Fees	**Q6:** Are there federal guidelines on whether QHP issuers can impose late payment fees on groups participating in the FF-SHOPs?	**A6:** Currently, there are no federal standards or guidelines that address late payment fees.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Enrollment Files	**Q7:** Will CMS send 834 enrollment transactions the same night as the group XML load file?	**A7:** Yes, CMS will send 834 enrollment transactions the same night as the group XML load file.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Enrollment Files	**Q8:** Will the termination dates for enrollees be populated on the ASC X12 834 enrollment transaction file or will they remain open until enrollees terminate?	**A8:** No termination dates are sent on initial enrollment transactions. The termination date field in the ASC X12 834 enrollment transaction file will remain open until the enrollment is terminated.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Enrollment Files	**Q9:** Because CMS will not send the employer group number when issuers receive the original ASC X12 834 enrollment transaction file, how will issuers know which group to categorize them	**A9:** Issuers may link Group enrollment information with ASC X12 834 enrollment transaction files using the Employer Identification Number (EIN).	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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	under?				
Federally-facilitated Marketplace for SHOP: Enrollment Files	**Q10:** A previous Q&A response stated that changes to enrollment and other member-level changes will be handled through the ASC X12 834 enrollment transaction. Will other changes at the group level be sent via an XML file (e.g., broker, group contact information, etc.)?	**A10:** When employer-level information included in the original Group Enrollment XML file changes, the updated information will be transmitted to the issuer via a subsequent Group Enrollment XML file.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Payment Files	**Q11:** How does the Payment Discrepancy report apply to issuers in the FF-SHOPs in 2014?	**A11:** The Payment Discrepancy report will not apply to issuers with FF-SHOP plans having effective dates beginning in 2014.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Payment Files	**Q12:** Since issuers are handling billing in the first year, is CMS requiring issuers to report premium payments to the FF-SHOP for 2014?	**A12:** No, CMS is not requiring issuers to report premium payments to the FF-SHOP for 2014.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Payment Files	**Q13:** Will CMS send issuers ASC X12 or HIX 820 premium	**A13:** No, CMS will not be sending issuers any type of ASC X12 or HIX 820 premium payment transaction files	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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	payment transaction files for the FF-SHOP in 2014?	in 2014.			
Federally-facilitated Marketplace for SHOP: Payment Files	**Q14:** How will issuers know the FF-SHOP quoted premium dollar amount for the first premium payment?	**A14:** Premium payment information will be contained in an applicable ASC X12 834 enrollment transaction file and in any applicable payment redirect transactions sent to issuers.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Payment Files	**Q15:** What information will the payment redirect contain?	**A15:** Please refer to zONE for the payment redirect BSD (https://zone.cms.gov/system/files/documents/SBS-EXCH-EE-209_Payment_Redirect_to_Issuer_Payment_Portal_BSD.pdf).	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Payment Files	**Q16:** What is the intent and purpose of the "Payment ID" that issuers can expect on the Group XML?	**A16:** Payment Transaction ID is a field that will be used to assist in the identification of payments from a participating employer. This ID will occur in the Group Enrollment transaction and any redirect occurring between the FF-SHOP and an issuer's payment portal.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Allowable Terminations	**Q17:** What reasons may an issuer terminate a group in the FF-SHOP?	**A17:** Issuers may terminate FF-SHOP group coverage for lack of payment and/or for instances of fraud.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Delinquency Notices	**Q18:** Are issuers responsible for handling delinquency notifications, and can issuers terminate employers for non-payment of premium	**A18:** QHP issuers are responsible for delinquency notifications and may terminate groups for non-payment of premium before notifying the FF-SHOP. For 2014, QHP issuers must defer to state law regarding delinquency notifications and allowable termination	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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	before notifying the FF-SHOP?	procedures regarding non-payment of premiums.			
Federally-facilitated Marketplace for SHOP: Special Enrollment Periods	**Q19:** Will the FF-SHOP validate Special Enrollment Period (SEP) reasons, such as legal guardianship? Is the issuer expected to maintain enrollment of plan members using the ASC X12 834 enrollment transaction, or is there additional validation for the issuer to perform?	**A19:** No, the FF-SHOP will not validate SEP reasons at the time of enrollment. Information provided by an employee regarding their dependents is signed under the penalty of perjury. In addition, CMS may conduct dependent verification audits. Any QHP issuer participating in the FF-SHOP must maintain enrollment of members in accordance with 45 C.F.R. §156.285.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Account Maintenance	**Q20:** Can FF-SHOP enrollees make demographic and product-related changes directly with the issuers or should issuers direct enrollees to the FF-SHOP?	**A20:** Enrollment and demographic changes should be made directly with the FF-SHOP, as it is the enrollment system of record.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Exception Process	**Q21:** What is the exception process to handle out-of-state participation?	**A21:** There is no exception allowance for out-of-state participation. Only employers with a business location in a given state may participate in the FF-SHOP serving that state.	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf
Federally-facilitated Marketplace for SHOP: Geographic Rating Factor	**Q22:** In the case where an employer group moves its	**A22:** An issuer offering coverage in the small group market outside the SHOP may re-rate an employer in accordance	FAQ July 30, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ3_073013_5CR_080913.pdf

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	headquarters (a change in primary business location) or an individual makes a permanent move (change in primary address) and that move is to a different rating area, would issuers be permitted to apply the new geographic rating factor to the coverage?	with the established rating factors under 45 CFR 147.102. This includes applying a new geographic rating area factor as a result of a permanent move. Pursuant to 155.705(b)(6)(ii), the SHOP will prohibit QHP issuers from varying rates for a qualified employer during the employer's plan year. QHP issuers and the FF-SHOPs, therefore, may apply a new geographic rating factor only upon renewal. If an employer group moves its headquarters to a different rating area, the FF-SHOP will re-run the eligibility process to verify that the employer is still located in the same state. If the employer moves to a different state, the employer will lose eligibility status in the state. Note that under 147.104(a)(2), an individual would have a special enrollment right to purchase any individual market coverage that becomes available as a result of a permanent move.			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q1:** HHS stated that cost sharing towards services that are essential health benefits (EHB) must accumulate towards the maximum out-of-pocket limit (MOOP). If an issuer covers benefits that are not EHB, can	**A1:** For purposes of calculating AV, 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	those benefits also accumulate towards MOOP? 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. Is this permissible?	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 benefits be provided to a standard population. However, operationally, a plan may (but is not required to) count cost sharing for non–EHB towards the MOOP.			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q2:** Does the one-year transitional exemption to the statutory out-of-pocket maximum, described in the Annual Letter to Issuers in Chapter 1, Section 4(iii), apply where a small group market Issuer has a	**A2:** Yes. A small group market Issuer that uses multiple benefit administrators to administer its major medical benefits separate from its dental benefits will be considered to meet the maximum out of pocket limits as long as: 1. The plan complies with the annual out-of-pocket maximum with respect to its major medical coverage; and 2. To the extent that the plan includes an	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	dental benefit that is separately administered from its major medical benefits?	out-of-pocket maximum on its separately administered dental coverage, such out-of-pocket maximum does not exceed the dollar amounts set forth in section 1302(c)(1).			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q3:** We would like confirmation that the reasonable assurance provision in the EHB preamble applies to both individual and small group coverage.	**A3:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q4:** 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?	**A4:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q5:** 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	**A5:** 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).	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	individual carriers, or all benefits (including those listed as "other" in the CCIIO template)?				
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q6:** 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?	**A6:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q7:** Are pre-existing condition exclusions permitted on stand-alone pediatric dental plans?	**A7:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q8:** Are issuers allowed to include a 24-month waiting period for orthodontia services (currently part of the	**A8:** Yes, this is permissible.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	FEDVIP benchmark) for both stand-alone pediatric dental and an embedded medical product that includes the pediatric dental EHB?				
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q9:** 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?	**A9:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version	**Q10:** In preamble to the EHB final rule published February 25, 2013 page 12850 made note of a safe	**A10:** 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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2, released May 9, 2013	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?	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.			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q11:** 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	**A11:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	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				

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	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?				
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q12:** 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?	**A12:** No, this is not permissible.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential	**Q13:** If the health plans are using the	**A13:** For the purposes of completing the application for certification of stand-	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	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)?	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			

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		issuers of stand-alone dental plans."			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q14:** 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	**A14:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	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.				
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q15:** 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	**A15:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	visits or prescription drugs) rather than making them subject to the deductible. Issuers could also choose not to have a deductible at all.				
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q16:** 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.	**A16:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q17:** What further details can you provide on how states will reimburse issuers for benefit offer mandates (i.e.,	**A17:** 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	requirements to make a benefit optional through a rider) that are required to be offered in addition to the EHB?	not mandate that the issuer actually provide the benefit to all enrollees in that market.			
Qualified Health Plan Webinar Series: Essential Health Benefits: Clarification of Q/A #12 from FAQs #10, Version 2, released May 9, 2013	**Q18:** 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)?	**A18:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Federal Exchange	**Q19:** Will issuer logos display on the FFE website?	**A19:** No, logos will not be displayed on the FFE website.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Federal Exchange	**Q20:** 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	**A20:** 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	questions regarding product offerings or how to enroll?				
Qualified Health Plan Webinar Series: Federal Exchange	**Q21:** 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.	**A21:** 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: o Different network; o Different formulary; o $50 or more difference in both individual and family in-network deductibles; o $100 or more difference in both individual and family in-network maximum-out-of-pocket; and o 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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		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."			
Qualified Health Plan Webinar Series: Exchange Forms	**Q22:** 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?	**A22:** Specific requirements for selling off the Exchange are of the purview of the state.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Form Review	**Q23:** 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?	**A23:** 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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		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.			
Qualified Health Plan Webinar Series: Form Review	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan	**Q25:** Could an issuer	**A25:** Issuers may enter into contracts	FAQ August 2,	CMS	https://www.regtap.info/uploads/library/

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Webinar Series: Essential Community Providers (ECPs)	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.	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.	2013		PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: 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	**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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	companies or emergency rooms accrue to the in-network out-of-pocket maximum?	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.			
Qualified Health Plan Webinar Series: Cost Sharing	**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)).	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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		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.			
Qualified Health Plan Webinar Series: 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: 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	**A30:** 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-	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	aggregation?	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.			
Qualified Health Plan Webinar Series: SHOP	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: SHOP	**Q32:** Will the geographic area premium rating factor in the small group market be based on the	**A32:** 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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	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?	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.			
Qualified Health Plan Webinar Series: SHOP	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: SHOP	**Q34:** Will there be a call center supporting employers and agents/brokers	**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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	working with SHOP?	matters. Agents and brokers working with employers will also be able to access the SHOP call center.			
Qualified Health Plan Webinar Series: SHOP	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: SHOP	**Q36:** Will CMS be providing guidance related to the reconciliation process and/or the	**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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	content of the monthly reconciliation file?	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.			
Qualified Health Plan Webinar Series: SHOP	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: Benefits Template	**Q38:** We have a question on an item on the Summary of Benefits and Coverage (SBC)	**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	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	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?	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.			
Qualified Health Plan Webinar Series: 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: State Mandates	**Q40:** If a state enacts a new requirement that issuers that provide coverage of intravenous (IV) chemotherapy must cover oral chemotherapy at	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	parity, does the state have to defray the cost?				
Qualified Health Plan Webinar Series: State Mandates	**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).	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Qualified Health Plan Webinar Series: State	**Q42:** Our state has a mandated adoption	**A42:** As stated in the preamble to the final rule on EHB at 78 FR 12838, we	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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Mandates	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	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.			

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	dollar limit have to be removed?				
Qualified Health Plan Webinar Series: 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)	**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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	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?				
Qualified Health Plan Webinar Series: Grace Periods	**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,	**A44:** Yes, the issuer should provide the full 90-day supply, pursuant to 45 CFR 156.270(d).	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf

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	does a QHP issuer have to provide the full 90-day supply if an enrollee is in the first month of the grace period?				
Qualified Health Plan Webinar Series: 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.	FAQ August 2, 2013	CMS	https://www.regtap.info/uploads/library/PM_FAQ10v3_5cr_080213.pdf
Enrollment and Transaction: Policy and Technical Information	**Q1:** Will subscribers who are eligible for the Advance Premium Tax Credits (APTC) but elect $0 APTC, still qualify for the 90 day grace period for non-payment of premiums?	**A1:** No. Per § 156.270(d) of the Exchange Final Rule, the enrollee must be *receiving* APTC to qualify for the 3 month grace period.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and	**Q2:** How does the Marketplace expect	**A2:** The Issuers are still expected to distribute the SBCs in accordance with	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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Technical Information	health plans to handle distribution of the Summary of Benefits and Coverage (SBCs)? Regulation requires SBCs to be sent to applicants within 7 days of submitting the application. Will there be exceptions for Exchange enrollment? If yes, what are the exceptions? Will the Exchange be able to get enrollment to the carriers in time for carriers to make the 7 day requirement?	current law; within seven days of QHP issuer receipt of the enrollment transaction from the FFM. The Federally-facilitated Marketplace (FFM) does not anticipate the need for exceptions because Issuers will receive the enrollment transaction within the same 24 hour period as the enrollee makes his/her selection of QHP – or submission of the application. Thus, the FFM will be getting enrollment to the Issuers in time to meet the 7 day requirement.			
Enrollment and Transaction: Policy and Technical Information	**Q3:** Will the FFM or the Issuer have the responsibility for terminating over age dependents? Who will own the notice requirements related to determination? Given the policy holders Advance Premium Tax Credit (APTC) will be impacted, what is the requirement for the timing of a new	**A3:** We are developing guidance on the subject of terminations for over age dependents and will release that to Issuers soon.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	Exchange eligibility determination? If the issuer owns such determinations, how should notice be provided to the FFM in the 834, and what is the process for maintaining coverage in the case of disability, or state law requiring maintaining of coverage (e.g., full-time students, veteran's, etc.)?				
Enrollment and Transaction: Policy and Technical Information	**Q4:** This is a question about pro-ration. The subscriber, eligible for Advance Premium Tax Credits and/or Cost Sharing Reductions (APTC/CSR), is cancelled mid-month due to death. The APTC/CSR has already been paid to the issuer for the month. Firstly, does the carrier have to refund the APTC? If yes, is the refund calculated on a pro-	**A4:** IRS just recently published proposed rulemaking on this topic. CMS is working with the IRS on the disposition of refunds for APTC/CSR under various scenarios. We anticipate discussing this topic on an upcoming issuer engagement call.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	rated basis? Or is it refunded retro-actively to the beginning of the month? Does the policy apply to the CSR? Secondly, for the CSR, which will be reconciled annually, does the refund get processed and paid throughout the year as events occur, or will it be part of the yearly reconciliation process that occurs after the calendar year and the claims run out period?				
Enrollment and Transaction: Policy and Technical Information	**Q5:** For the State Based Marketplace (SBM), is the ASC X12 834 enrollment transaction sent to the FFM at the same time it is sent to the Issuer? Or does the SBM wait until the issuer has confirmed receipt of the 834 and "effectuated" coverage before they send the 834 to the FFM?	**A5:** SBMs have various business models. Some SBMs collect/aggregate the initial month's premium, and therefore may not require a "confirmation" (effectuation) transaction from Issuers. SBMs will determine the timing of their transactions to CMS.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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Enrollment and Transaction: Policy and Technical Information	**Q6:** With respect to the SHOP program, is there a possibility that a benefit year will not match a contract year? Will Issuers be permitted to have benefit years that differ from the contract years for small groups?	**A6:** Yes, if state law allows it, it is possible that a benefit year will not match a contract year in the FF-SHOPs for 2014. This information would need to be communicated to consumers clearly in plan benefit materials provided by Issuers to employers and employees. For 2016, CMS is considering requiring all small group market plans to use a benefit year contract year unless state law requires otherwise.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q7:** Name Normalization: On the ASC X12 834 enrollment file, will the Federally-facilitated Marketplace (FFM) be performing any name normalization? If so, will an enhanced character set be used? Can the member name sent from the Marketplace be changed (based on name normalization on the issuer side)?	**A7:** The Federally-facilitated Marketplace will not be performing name normalization, and no enhanced character set is planned for use with the ASC X12 834 enrollment transaction. The member's name cannot be changed based on information obtained by name normalization on the issuer side; however, the issuer can report such information during reconciliation. An individual who wishes to correct personal information such as his or her name must do so through the FFM.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q8:** Can multiple acknowledgement files (999) be sent back for one	**A8:** Yes, Issuers may send multiple acknowledgement files (999s) back for one incoming (physical) enrollment file.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	incoming enrollment file?				
Enrollment and Transaction: Policy and Technical Information	**Q9:** Can the TA1 and 999 acknowledgements for the ASC X12 834 enrollment file be sent together?	**A9:** Yes, Per the ASC X12 Implementation Guides, a TA1 can be included in an interchange with other functional groups and transactions.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q10:** When we will be able to sign Trading Partner Agreements?	**A10:** The Trading Partner Agreement process is under development. Background information and current updates about the Trading Partner Agreements can be found on the Issuer Community in the zONE.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q11:** On the initial enrollment file layout, as indicated in the most recent CMS/FFE Enrollment Companion Guide (v 1.5 from March), the only date that is indicated is at the file/transaction level. There do not appear to be any member or coverage level dates in the initial enrollment 834 from the FFE, only the transaction date. Is this is intentional or an oversight?	**A11:** The CMS Enrollment Companion guide is to be used in conjunction with the applicable ASC X12 Implementation Guide TR3. A data element is included in the Companion Guide to provide unique or specific information about how the date would be used by the FFM. Dates will be included in transactions when applicable (required by the TR3).	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	Shouldn't the FFE be sending member (2000 loop) and coverage (2300 loop) dates in the initial enrollment 834? Is the FFE intentionally not sending dates - as the date is determined by receipt of payment and EARLIEST effectuation date within the carrier's system? If yes, are there any guidelines regarding whether the EARLIEST effectuation date is the beginning of the next month? Or the beginning of the month following the next month?				
Enrollment and Transaction: Policy and Technical Information	**Q12:** How will carriers identify Tribal members if they are not enrolled in an American Indian /American Native (AI/AN) plan variation?	**A12:** There are no standard ways by which an issuer will be able to identify a tribal member, unless the individual self-identifies in the application and therefore selects and enrolls in an AI/AN plan. CMS will not provide a flag for tribal members. However, we would be interested in further discussion to understand if and why Issuers need to know if someone is a tribal member if they are not enrolled in an AI/AN plan.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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Enrollment and Transaction: Policy and Technical Information	**Q13:** Regarding the reporting of dollar amounts in the 2750 REF02 field, do dollar amounts always need to include two places to the right of the decimal? Also please confirm that a $ dollar sign does NOT need to precede the REF02 amounts.	**A13:** Yes, the dollar amounts do need to include two places to the right of the decimal, and the $ sign does **not** need to precede the REF02 amounts. CMS will not send the dollar sign in the enrollment transactions. This information has been updated in the CMS Enrollment Companion Guide.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q14:** What is the list of special enrollment period reasons, and how will these be used on the ASC X12 834 enrollment transaction? Will the CMS Enrollment Companion Guide list them in Table 12?	**A14:** The Special Enrollment Reason codes that will appear on the 834 enrollment transaction include the items below. These codes will be used in the individual Member Reporting Category Loop (See page 57 of the Version 5010 Implementation Guide). The identifier in the REF01 "17" says it is a Client Reporting Category, which points to the N102 segment containing a value for the "SEP REASON. This list will be included at the end of the updated version of the Companion Guide. The SEP Reason codes are as follows: (1) Qualified Individual (QI) or dependent loss of Minimum Essential Coverage (MEC); 07-Termination of Benefits, located in the INS04-Maintenance Reason Code. (2) QI gains or becomes a dependent due to marriage, birth, adoption or placement of adoption; 32-Marriage, 02-	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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		Birth, 05-Adoption, located in the INS04 – Maintenance Reason Code. (3) An individual, who was not previously a citizen, national or lawfully present individual gain such status; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (4) A QI enrollment or non-enrollment in a QHP is the result of an Exchange ERROR; EXCHANGE ERROR, located in the 2750 as SEP REASON. (5) Qualified Health Plan (QHP) is in violation of material provision of its contract with the enrollee; AB/Dissatisfied with medical care/service rendered, located in the INS04-Maintenance Reason Code. (6) Newly eligible for Advance Premium Tax Credit (APTC) or change in Cost Sharing Reduction (CSR); FINANCIAL CHANGE, located in the 2750 as SEP REASON. (7) New QHPs available due to a permanent move; 43-Change of Location, located in the INS04-Maintenance Reason Code. (8) Indian; NEWLY ELIGIBLE, located in the 2750 as SEP REASON. (9) Exceptional Circumstances; EXCEPTIONAL CIRCUMSTANCES, located in the 2750 as SEP REASON.			
Enrollment and Transaction: Policy and Technical Information	**Q15:** Does the payment transaction ID (2000, REF02 where REF01 = 6O)	**A15:** Yes. In Section 10.2 Enrollment Confirmation/Effectuation Instructions, titled: "QHP Issuer to FFE," the Companion Guide states: Except where	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	need to be sent back on the 834 confirmation file?	overruled by the usage requirements of the 005010X220 TR3, QHP Issuers must return all the information transmitted on the Initial Enrollment Transaction in addition to the information detailed below."			
Enrollment and Transaction: Policy and Technical Information	**Q16:** Policy Number - Issuers are to send the enrollee's policy number back to the Federally-facilitated Marketplace (FFM). How will the FFM use the policy number (an identifier, customer service, etc.)? This pertains to loop 2300, REF02 Member Group or Policy Number - Issuer assigned health coverage purchased policy number. The identifier is required on Confirmation Transactions. It is different than loop 2000 REF02 Member Supplemental Identifier which is the issuer assigned subscriber ID.	**A16:** The term for policy number in the ASC X12 834 Implementation guide has the same meaning as the Issuer assigned health coverage purchased policy number, and is the same as the Issuer Assigned Policy number. This identifier will be returned to the issuer on subsequent transactions where appropriate, and it will also be used in Monthly IRS reporting when required. The Federally-facilitated Marketplace (FFM) is considering use of the issuer's assigned enrollee's policy number during reconciliation processing If the issuer uses the policy number as the Subscriber Number, it should be included in both member identifier data elements of the 834.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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Enrollment and Transaction: Policy and Technical Information	**Q17:** Employer Paid Amount: Is the employer paid amount a dollar amount or a percentage? Or can it be one or the other? If it can be one or the other, how is that designated on the 834 file?	**A17:** The employer paid amount or employer responsibility amount is a dollar amount. Details about this field can be found in Section 9.6.2 SHOP Market: 2750 Member Reporting Categories Loop, Table 14. In the ASC X12 834 enrollment transaction, the SHOP Member Reporting Category Loop lists the format of the employer paid amount as: NNNNNNNN.NN	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
Enrollment and Transaction: Policy and Technical Information	**Q18:** In the March 27, 2013 webinar called "Enrollment in the Federally Facilitated-SHOP Market webinar, a new value is being sent in the 2750 loop - REQUEST SUBMIT TIMESTAMP. This value is not mentioned in the CMS/FFE Companion Guide. What does this value represent? Should it be returned on the ASC X12 834 confirmations? If yes, should it be the same date/time as received on the inbound 834 to the	**A18:** This data element will be included in the next version of the Companion Guide. It is the [REQUEST SUBMIT TIMESTAMP] – CurrentTimeStamp. This timestamp is captured at the time the Application Filer selects and presses the "CONFIRM" button on their enrollment choice. The timestamp was added to help maintain the correct order of transactions in daily files.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf

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	carrier?				
Enrollment and Transaction: Policy and Technical Information	**Q19:** We understand the Exchange will send the National Producer Number (NPN) if available. However, since the Navigator and Broker use the same field on the application, will the Federally-facilitated Marketplace (FFM) only send the NPN or is it possible that Issuers will receive a code and information for brokers and a code and information for navigators in the same position?	**A19:** The enrollment transaction will only carry the broker information in the N1 Segment, Loop 1000C; the Federally-facilitated Marketplace will not send information for the Navigators, as this information was not mapped for the 834 transaction.	FAQ July 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ3_5CR_072413.pdf
MLR Reporting of Affordable Care Act Fees	**Q1:** When may an issuer exclude Affordable Care Act fees, such as those required by ACA §9010, from premium in its MLR and rebate calculations?	**A1:** Issuers may exclude ACA assessments or fees from MLR calculations for a reporting year only if such assessments or fees were incurred in that reporting year. Issuers may not exclude ACA assessments or fees they expect to incur in future MLR reporting years. Specifically, an issuer may not report such amounts as assessments and fees described in 45 CFR §158.161(a) and §158.162(a)(1) and (b)(1), or as unearned premium described in 45 CFR §158.130(b)(4). As discussed in the	FAQ July 2, 2013	CMS	MLR FAQ July 2013.pdf

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		HHS Notice of Benefit and Payment Parameters for 2014, published on March 11, 2013, "PHS Act section 2718 does not provide for estimated regulatory fees for future years to be deducted from premium used in MLR and rebate calculations for the reporting year." 78 FR 15410 at 15505-15506.			
Health Insurance Marketplaces and Income Verification	**Q1:** Will Marketplaces be verifying the income of consumers as a part of the eligibility process for advance payments of the premium tax credit and cost-sharing reductions?	**A1:** Yes. According to 45 CFR 155.320(c)(3), Marketplaces will always use data from tax filings and Social Security data to verify household income information provided on an application, and in many cases, will also use current wage information that is available electronically. The multi-step process begins when an application filer applies for insurance affordability programs (including advance payments of the premium tax credit and cost-sharing reductions) through the Marketplace and affirms or inputs their projected annual household income. The applicant's inputted projected annual household income is then compared with information available from the Internal Revenue Service (IRS) and Social Security Administration (SSA). If the data submitted as part of the application cannot be verified using IRS and SSA data, then the information is compared with wage information from employers provided by Equifax. If Equifax data does not substantiate the inputted information, the Marketplace	FAQ August 5, 2013		http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/income-verification-8-5-2013.pdf

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		will request an explanation or additional documentation to substantiate the applicant's household income. When documentation is requested, the Affordable Care Act and implementing regulations specify that if the applicant meets all other eligibility requirements, he or she will be provided with eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the inputted projected annual household income for 90 days (which may be extended based on good faith), provided that the tax filer attests to the Marketplace that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation. If documentation is requested and is not provided within the specified timeframe, regulations specify that the Marketplace will base its eligibility determination on IRS and SSA data, unless IRS data is unavailable, in which case the Marketplace will discontinue any advance payments of the premium tax credit and cost-sharing reductions. For 2014 only, we recently indicated that HHS will exercise enforcement discretion such that a Marketplace may choose to request additional documentation from a statistically-significant sample of the group of individuals in only one specific			

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		situation: when the Marketplace has IRS data, the application filer inputs projected annual household income that is more than ten percent below IRS and SSA data, Equifax data is unavailable, and the individual does not provide a reasonable explanation for the inconsistency between the attestation and IRS and SSA data. In all other cases in which the data submitted by the individual cannot be verified using IRS and SSA data or Equifax data, and the individual does not provide a reasonable explanation for any discrepancy identified between their attestation and electronic data, the Marketplace must request additional documentation. This includes, for example, all cases in which IRS data is not available for an individual, and the attestation to projected annual household income cannot be verified using Equifax data; and all cases in which there is both IRS data and Equifax data for an individual but the attestation to projected annual household income cannot be verified using that data. We are clarifying that, for the Federally-facilitated Marketplace, CMS intends to set the initial size of the sample at 100 percent, such that everyone who is in the circumstance described above in which sampling may be used is asked to submit satisfactory documentation. Since publication of the final rule, we			

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		have ascertained that there are sufficient resources to ask every individual in this circumstance for such documentation with no exceptions. State-based Marketplaces may choose to use other sample sizes, provided that they are statistically significant for 2014. As described 45 CFR 155.320(c)(3)(vi)(F), if satisfactory documentation is not submitted by the end of the resolution period, the Marketplace will determine eligibility based on the IRS and SSA data. We note that application filers must attest, under penalty of perjury, that they are not providing false or fraudulent information. In addition to the existing penalties for perjury, the Affordable Care Act applies penalties when an individual fails to provide correct information based on negligence or disregard of program rules, or knowingly and willfully provides false or fraudulent information. Moreover, the IRS will reconcile advance payments of the premium tax credit when consumers file their annual tax returns at the end of the year, and it will recoup overpayments and provide refunds when appropriate, subject to statutory limits. These safeguards all apply no matter which type of Marketplace is operating in a state.			

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Reinsurance and Risk Adjustment/Data Elements	**Q1:** Should only paid claims be submitted to the Edge Server? Or are administratively denied claims allowed as well?	**A1.** Denied claims are not acceptable for submission to the Edge Server. The Edge Server will not accept claims that have a $0 allowed amount at the claim header. A $0 allowed amount at the line level, on institutional claims, is acceptable for services that are covered under a more inclusive reimbursement such as DRG or case rate. For capitated services, Issuers will need to derive (or estimate) a paid amount for these services. In addition, the inbound claim file layout contains a field to indicate a derived amount has been computed for capitated arrangements (45 CFR §153.710(c)). Please note that this derived amount field does not apply to denied claims in full or partial fee-for-service payment arrangements. Further information and specific file layouts pertaining to capitated arrangements were covered in the May 8, 2013 Distributed Data Collection (Edge Server) webinar (webinar materials are available in the REGTAP Library at https://www.regtap.info).	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Reinsurance and Risk Adjustment/Data Elements	**Q2:** If a medical claim has multiple lines and one of the paid amounts is derived, how is that reported at the header level?	**A2:** If a medical claim includes both derived and paid amounts, then the header should include the derived indicator value of "Y". At the line level, each line should include the appropriate value which indicates whether the value is derived.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Reinsurance and Risk	**Q3:** Do issuers	**A3:** At the claim header, a medical	FAQ August 16,	CMS	https://www.regtap.info/uploads/library/

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Adjustment/Data Elements	submit zero paid claims, such as scenarios where the entire allowed amount went to the deductible?	claim may be submitted with a $0.00 paid amount, for example, if a deductible covered the full cost, as long as the header allowable amount is greater than $0.00. In the case of an inpatient stay, where a case rate or DRG was paid, the paid and allowable amounts at the line level may both be equal to or greater than $0.00.	2013		DDC_RI_RA_FAQ4_5CR_081613.pdf
Data Submission – Enrollment File	**Q4:** If an issuer receives only partial payment for a premium, what should they report on the enrollment file?	**A4:** The premium amount is the total premium charged for the policy, per month, to the enrollee or other responsible party and includes the APTC amount. It does not represent the amount paid.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Data Submission – Enrollment File	**Q5:** For the Enrollment Period Activity field on the Edge Server Enrollment Submission, what value do issuers use to report enrollment period change because of reduction in the number of dependents?	**A5:** According to the Interface Control Document (ICD) Table 9 (Business Data Element 'Enrollment Period Activity'), a change in the number of dependents would be communicated with value 001, 'Modification of existing policy.'	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Data Submission – Enrollment File	**Q6:** How frequently should claim and enrollment files be submitted to the Edge Server?	**A6:** As stated in the preamble of the HHS Notice of Benefit and Payment Parameters for 2014, Final Rule (Section III.G.2.h), HHS requests that issuers submit data at least quarterly throughout the benefit year. Issuers have the flexibility to submit more frequently	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf

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		(e.g., bi-weekly, monthly). HHS recommends monthly file submissions or more frequent submissions based on Issuer file size and processing time.			
Data Submission – Pharmacy File	**Q7:** Will pharmacy data need to be submitted to the Edge Server?	**A7:** Pharmacy claims data must be submitted to the Edge Server. Please refer to the latest version of the Interface Control Document (ICD) from the June 26, 2013 webinar. It can be found in the REGTAP Library at www.REGTAP.info.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Data Submission – Pharmacy File	**Q8:** Should rebates be included in the paid amount indicated on the pharmacy claim submission file?	**A8:** At this time, the reinsurance (RI) program is not considering pharmacy rebates in the calculation for RI payments.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Data Submission – Other	**Q9:** Should all medical and pharmacy data for Reinsurance eligible plans be placed on the Edge Server, or only data for enrollees whose claim costs exceed the attachment point be placed on the Edge Server?	**A9:** Claim and enrollment data submitted to the Edge Server is used for both the HHS operated risk adjustment and reinsurance program and should include all allowable services for all plans in the small group and individual markets. The CMS software will identify the claims that are eligible for risk adjustment and reinsurance by applying the provisions outlined in the Final Payment Notice.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Reports	**Q10:** What type of email notifications will we receive when the Edge Server outbound	**A10:** There are different types of email notifications. The first informs you whether the file met the three conditions to continue processing (i.e., in XML format, test/production zone, and file	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf

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	files/reports are ready?	type indicator - medical/pharmacy/enrollment type). That email will indicate if it accepted or failed and is not an actual outbound report. If accepted, it will provide a job ID. The Edge Server will then process the file, generate reports, and produce email notifications that reports are available. A Detail Accept or Reject report is produced for each file type that passes all the header verifications. This is sent only to the submitter and authorized receiver(s). CMS does not receive Detail Error reports. The Interface Control Document (ICD) Section 6.2, provides information about the specifications for outbound files. The ICD is available in the REGTAP Library at https://www.regtap.info .			
	Q11: Will a timeline be provided for the release of additional outbound data files/reports?	**A11:** As additional reports become available, information will be provided through a Release Management process.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
	Q12: Who receives notification that outbound Edge Server files/reports are available?	**A12:** An email notification is sent to the submitter when an outbound report is produced. This is sent only to the submitter and authorized receiver(s). The Interface Control Document (ICD) Section 6.2, provides information about the specifications for outbound files. The ICD is available in the REGTAP Library at https://www.regtap.info.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Documentation -	**Q13:** How will	**A13**: The Edge Server software code	FAQ August 16,	CMS	https://www.regtap.info/uploads/library/

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Training	information about the data stored in the reference tables be communicated?	includes reference tables. Updates to software or reference tables will be communicated through the release management process.	2013		DDC_RI_RA_FAQ4_5CR_081613.pdf
Other	**Q14:** When will sessions about risk adjustment and reinsurance be conducted?	**A14:** CMS will notify issuers of upcoming sessions on the risk adjustment and reinsurance programs through the REGTAP system. CMS anticipates providing information on reinsurance and risk adjustment calculations in 2014.	FAQ August 16, 2013	CMS	https://www.regtap.info/uploads/library/DDC_RI_RA_FAQ4_5CR_081613.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q1:** If an issuer elects not to participate in the payment redirect on the Federally-facilitated-SHOP (FF-SHOP) website, what will be the triggering event to send the Group Enrollment XML file?	**A1:** The triggering event to send the Group Enrollment XML file transaction will be when the employer completes the group enrollment. This occurs when the employer signs the application after closing the group's open enrollment period, and the system has calculated that the group meets any applicable minimum participation standard. The related ASC X12 834 enrollment transaction for the group's initial enrollment will be sent in a batched file the evening of the day in which the employer signs the application.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q2:** Please clarify CMS's meaning and intended use of the term “Payment Transaction ID.” If the issuer is managing the receipt of the binder payment (through its	**A2:** The Payment Transaction ID will occur in the Group Enrollment XML file transaction and any redirect occurring between the FF-SHOP and an issuer’s payment portal. When a new group enrolls, the FF-SHOP will send the issuer the group Employer Identification Number (EIN) and a system-generated Payment Transaction	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	own process after payment re-direct), what "Payment Transaction ID" will CMS provide?	ID. These values are used to connect the Group Enrollment XML file transaction with the associated ASC X12 834 enrollment transaction.			
Technical Guidance for the FF-SHOP/Group Set Up	**Q3:** Will CMS generate a unique group ID on the Group Enrollment XML file transaction?	**A3:** CMS will not generate a unique group ID on Group Enrollment XML file transactions for the FF-SHOPs. Instead, CMS will identify groups using their Employer Taxpayer Identification Number (TIN)/Employer Identification Number (EIN).	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q4:** Will issuers receive one Group Enrollment XML file transaction containing all new employer applications submitted that day?	**A4:** Group Enrollment XML file transactions are not batched on a daily basis. They will be sent to issuers throughout the day when an eligible employer signs and submits a completed application.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q5:** Are the Group Enrollment XML file transactions going to be available via Electronic File Transfer (EFT) similar to the Electronic Data Interchange (EDI) files?	**A5:** Group Enrollment XML file transactions will be made available to issuers via Electronic File Transfer (EFT), similar to Electronic Data Interchange (EDI) files. Please refer to the zOne for the Federal Data Services Hub Employer Group Business Service Definition (BSD): (https://zone.cms.gov/system/files/documents/DSH_RD_BSD_Employer_Group.docx).	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q6:** How do issuers match Group Enrollment XML file	**A6:** The Payment Transaction ID and the employer Taxpayer Identification Number (TIN)/Employer Identification	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	transactions to ASC X12 834 enrollment transaction records?	Number (EIN) are two data elements that may be used to match the Group Enrollment XML file transaction and associated ASC X12 834 enrollment transactions.			
Technical Guidance for the FF-SHOP/Group Set Up	**Q7:** Will Group Enrollment XML file transactions be sent to issuers that are not participating in the payment redirect option?	**A7:** Group Enrollment XML file transactions will be sent to all issuers (even those not participating in the payment redirect option) when the employer finalizes its group's enrollment. This occurs when the employer signs its application after closing the group's open enrollment period and the system has calculated that the group meets any applicable minimum participation standard. The related ASC X12 834 enrollment transaction for the group's initial enrollment will be sent in a batched file the evening of the day in which the employer signs the application.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Technical Guidance for the FF-SHOP/Group Set Up	**Q8:** If a binder payment is not received, does the FF-SHOP still require an issuer to send cancellation records with the QHP Member ID and QHP Subscriber ID? CMS requests this information in Loop 2000, REF01 – Qualifiers 23 (QHP	**A8:** While a cancellation transaction must be sent if a binder payment is not received, CMS does not require an issuer to send cancellation records with the QHP Member ID and QHP Subscriber ID. While these are optional data elements on the cancellation transaction, issuers should return FF-SHOP assigned Subscriber and Member identifiers.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	Member ID) or 24 (QHP Subscriber ID) and REF02 – value).				
Technical Guidance for the FF-SHOP/Group Set Up	**Q9:** Since CMS will be sending a group enrollment file via XML, could the FF-SHOP also send member eligibility terminations via XML file?	**A9:** No. The FF-SHOP and CMS will not use other conventions to send termination information. CMS will send terminations using the standard transaction in accordance with the ASC X12 834 enrollment transaction.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Agent/Broker Identifiers	**Q10:** How will the FF-SHOP transmit broker information and what information will be sent? Will broker information include an email address and other contact information?	**A10:** Broker information will be passed from the FF-SHOP to a Qualified Health Plan (QHP) issuer via Group Enrollment XML file transactions. At a minimum, the FF-SHOP expects to transmit the name and National Producer Number (NPN) of an agent/broker. Contact information is optional, but the FF-SHOP will send anything that is entered by the employer on the group application. Please see the FF-SHOP employer model application for the agent/broker data elements CMS expects to send to issuers: (http://www.reginfo.gov/public/servlet/ForwardServlet?SearchTarget=PRA&textfield=0938-1193).	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Agent/Broker Identifiers	**Q11:** What group identifier will be available for a group to use when communicating with an issuer or the FF-	**A11:** Groups will be identified by the employer's EIN/TIN when communicating with the FF-SHOP. This information is included in Group Enrollment XML file transactions and ASC X12 834 enrollment transactions	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	SHOP?	sent by the FF-SHOP to QHP-issuers. All enrollment changes need to be made directly on the FF-SHOP portal.			
Agent/Broker Identifiers	**Q12:** Will the ASC X12 834 enrollment transactions contain the issuer's group number?	**A12:** Initial ASC X12 834 enrollment transactions sent by the FF-SHOP to a QHP issuer will not contain the issuer's Policy ID, as the FF-SHOP will not yet possess this data. The initial ASC X12 834 enrollment transaction will include a temporary Policy ID, generated by the FF-SHOP. When the issuer responds with a confirmation 834 transaction, the FF-SHOP expects that the temporary Policy ID will be replaced with an issuer-generated Policy ID. Subsequent FF-SHOP generated ASC X12 834 enrollment transactions for a group's policy will include the issuer-generated Policy ID.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Agent/Broker Identifiers	**Q13:** For issuers not using the payment redirect, will there be a second group identifier available or just the employer TIN?	**A13:** A Payment Transaction ID will still be included in the Group Enrollment XML file transaction and ASC X12 834 enrollment transactions, regardless of whether a QHP issuer elects to accept payment via a payment portal.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
ASC X12 834 Enrollment Transactions	**Q14:** For each new group, will CMS be providing one ASC X12 834 enrollment transaction for all of the FF-SHOP groups enrolled for that day, or will CMS provide	**A14:** CMS will be providing one batch of ASC X12 834 enrollment transactions per day.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	separate ASC X12 834 enrollment transactions for each group**?**				
ASC X12 834 Enrollment Transactions	**Q15:** On the ASC X12 834 enrollment transaction, will CMS use the qualifier '1L' (i.e., group or policy number information) in the 2000 Loop in the member policy number segment?	**A15:** No, the value note/segment indicates the submitter sent the payer's pre-assigned group or policy number.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
ASC X12 834 Enrollment Transactions	**Q16**: Are SHOP ASC X12 834 enrollment transactions contained in the same files as ASC X12 834 enrollment transactions for individuals?	A16: No, ASC X12 834 enrollment transactions related to FF-SHOPs will be sent separately from ASC X12 834 enrollment transactions for individuals.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
ASC X12 834 Enrollment Transactions	**Q17:** Is the maintenance effective date considered the date of the transaction change or will it be the process date of the transaction?	A17: The maintenance effective date is the process date of the transaction.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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ASC X12 834 Enrollment Transactions	**Q18:** What information will be sent on ASC X12 834 enrollment change transactions?	**A18:** Change transactions will include information about demographic, address, etc. The minimum necessary data will depend on the type of change. Please refer to the Enrollment Transaction Companion Guide for information that will be sent on ASC X12 834 enrollment change transactions: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
ASC X12 834 Enrollment Transactions	**Q19:** Can an issuer in the FF-SHOP go past the effective date of coverage before sending the ASC X12 834 confirmation transaction to the FF-SHOP?	**A19:** Yes, the issuer may send the confirmation transaction to the FF-SHOP at any time. Thus, if an issuer receives the first month's premium payment late in the month, the issuer may send the confirmation transaction past the coverage effective date. The FF-SHOP will not automatically terminate a group if a confirmation transaction has not been received prior to the coverage effective date. The FF-SHOP will only cancel a group for non-payment of the first month's premium when the issuer sends a cancellation transaction.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
ASC X12 834 Enrollment Transactions	**Q20:** Are batched ASC X12 834 enrollment transactions all sent together? For example, are	**A20:** Yes, ASC X12 834 enrollment transactions are batched together by QHP ID.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	termination 834 transaction files, update 834 transaction files, and new enrollment 834 transaction files all sent together?				
Termination Transactions	**Q21:** What qualifiers should issuers use in Loop 2300 in the REF01 segment for termination transactions?	**A21:** All inbound cancellations and terminations from issuers are done at the subscriber level using dates at the 2000 level.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Out of State Participation	**Q22:** What is the exception process for out-of-state employer participation?	**A22:** Only employers with a business location within a given state may participate in the FF-SHOP serving that state. Multi-state employers may establish one FF-SHOP account and enroll in a QHP with multi-state provider networks. Alternatively, multi-state employers may establish a separate SHOP account in each state where they have a business location.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Payment ID	**Q23:** CMS has indicated in prior workgroup calls that the "Payment Transaction ID" will be the unique identifier associating the Group Enrollment XML file transaction with the member information	**A23:** The TIN, also known as the EIN, is a unique identifier included in the Group XML file transaction, ASC X12 834 enrollment transactions, and payment redirect data transmissions between FF-SHOPs and QHP issuers.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	on ASC X12 834 transaction files. Can CMS validate that this is, indeed, the only unique, group identifier between the Group Enrollment XML file transaction and ASC X12 834 transaction files.				
Payment ID	**Q24:** Will CMS only assign one Payment ID for binder payments (first month's premium) in 2014 for each group enrolling in FF-SHOPs?	**A24:** A single Payment ID will be used to identify a group, even if the group is redirected to the issuer multiple times to make a payment.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Timing of FF-SHOP Enrollment Transactions	**Q25:** During the annual November 15th – December 15th special enrollment period (when no minimum participation rate will be calculated), will the FF-SHOP send issuers a single enrollment file or will enrollment files be sent piecemeal as employees enroll?	**A25:** The Group Enrollment XML file transaction and associated ASC X12 834 enrollment transaction will not be sent until after the group's enrollment period has expired or all employees have responded to the offer of coverage. Thus, issuers will not be receiving ASC X12 834 enrollment transactions in a piecemeal manner.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Timing of FF-SHOP	**Q26:** Since the FF-	**A26:** The transmission of SHOP	FAQ August	CMS	https://www.regtap.info/uploads/library/

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Enrollment Transactions	SHOP allows a rolling open enrollment period, will all the ASC X12 834 enrollment transactions be held until December 15th for January 1st coverage?	enrollments, including Group Enrollment XML file transactions and ASC X12 834 enrollment transactions will start when open enrollment begins. Thus, the transmission of this information will not be held until December 15, 2013.	28, 2013		SHOP_FAQ4_082713_5CR_082813.pdf
Timing of FF-SHOP Enrollment Transactions	**Q27:** What are the cycle time expectations for issuers to establish a new group and process an associated ASC X12 834 enrollment transaction?	**A27:** The Group Enrollment XML file transaction is sent the same day as the ASC X12 834 enrollment transaction. We assume issuers will add both the employer group and the members as soon as possible within their established business processes.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/ SHOP_FAQ4_082713_5CR_082813.pdf
Group XML Acknowledgement	**Q28:** Please confirm that issuers are not required to provide an acknowledgment following receipt of a Group Enrollment XML file transaction.	**A28:** No acknowledgement to the Group Enrollment XML file transaction is expected by an issuer. An issuer need only acknowledge the receipt of the ASC X12 834 enrollment transaction via a ASC X12C Acknowledgement (999) transaction and subsequently return either a confirmation ASC X12 834 or a cancellation ASC X12 834 enrollment transaction.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/ SHOP_FAQ4_082713_5CR_082813.pdf
Minimum Participation Rate	**Q29:** How will the minimum participation rate be effected if changes are made that impact the eligibility of the	**A29:** Employers that no longer meet FF-SHOP eligibility criteria as described in 45 CFR § 155.710 of the HHS Final Exchange Establishment Rule (http://www.gpo.gov/fdsys/pkg/FR-	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/ SHOP_FAQ4_082713_5CR_082813.pdf

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	group? For example, what will happen if an employee cancels before group coverage is effectuated, resulting in a reduced participation rate?	2012-03-27/pdf/2012-6125.pdf) may no longer participate in the FF-SHOP. Minimum participation rates are calculated once a year at the time of initial group submission and subsequently at the time of renewal.			
Minimum Participation Rate	**Q30:** Will a group's existing COBRA members be included in the minimum participation rate calculation for SHOP?	**A30:** Yes, all COBRA employees listed on the employee roster will be included in the initial minimum participation rate calculation.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Women's Contraceptive Benefit	**Q31:** Will the FF-SHOP provide women's preventive benefit information on the Group Enrollment XML file transaction sent to issuers?	**A31:** No, the Group Enrollment XML file transaction will not contain information regarding this benefit. An issuer will need to communicate information regarding this benefit directly with the group plan's administrator.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Termination Notices	**Q32:** Can CMS please clarify how the "Termination of coverage for qualified individuals" requirements in 45 CFR § 156.270 of the HHS Final Exchange Establishment Rule	**A32:** The pertinent regulatory citation, 45 CFR § 155.270(b) of the HHS Final Exchange Establishment Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) has been updated to resolve this discrepancy. Under the new standard, for the termination reasons cited in the paragraph, such notice must be provided "promptly and without undue delay."	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	applies to issuers offering QHPs in the FF-SHOPs? Regulation 45 CFR § 156.270 requires notifications to be sent to "enrollees" 30 days prior to the last day of coverage. What is considered to be "the last day of coverage"?				
Termination Notices	**Q33:** Can CMS please confirm that issuers are required to send termination notifications to each "enrollee" and that billing timeframes, notices, and pending claims will be between issuers and employers.	**A33:** Per 45 CFR § 156.270(b) of the HHS Final Exchange Establishment Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf), "If a QHP issuer terminates an enrollee's coverage in accordance with 45 CFR § 155.430(b)(1)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay: Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination." In 2014, issuers should follow state rules pertaining to billing timeframes and pending claims.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
820 Transactions	**Q34:** The payment code listed as "COMM", reflects "Any commissions withheld by the exchange." It is our	**A34:** This payment code will not be used by the FF-SHOP because no broker commissions will be withheld by the FF-SHOPs.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	understanding that issuers will be paying broker commissions. What commissions does the FF-SHOP plan to withhold?				
COBRA	**Q35:** If an employer is allowed to enroll employees in COBRA, how do we know who (employer or employee) will pay the COBRA premium?	**Q36:** Requirements for premium payment with respect to COBRA are not modified by FF-SHOPs. Thus, issuers should use standard COBRA billing practices allowed by state and federal regulations for plan years beginning in 2014.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Payment URL	**Q36:** How will an issuer submit a different URL for payment redirect for employers on SHOP versus individual market plans?	**A36:** The URL for Enrollment Payment redirect is reported to CMS by a QHP issuer on its QHP application under the "Plan Attributes" section. This field is plan specific and the issuer may change it from plan to plan; therefore, the issuer may have a different URL for SHOP versus Individual Market plans.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Coverage Effective Dates	**Q37:** Since employers will be determining waiting periods and effective dates at the level of the FF-SHOP, will the FF-SHOP ever set up a group with coverage effectuating on a day other than the first of a month?	**A37:** Coverage for a group initially enrolling in the FF-SHOP will always be the first of the month. New hire effective dates will also always be the first of the month after any applicable waiting period has expired.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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Coverage Effective Dates	**Q38:** In the FF-SHOP, will the effective date of coverage always be the first of the following month if an initial enrollment application is received by the 15th of the month? Additionally, would the effective date of coverage be the first day of the following month if an enrollment application is received after the 15th of the month (with an exception for birth or adoption of a child where the effective date is the day of the qualifying event)? Will the FF-SHOP allow for retroactive enrollment?	**A38**: For groups enrolling for the first time, the effective date of coverage is based on when an employer submits the initial application. An employer must enroll by the 15th of the month to effectuate coverage on the first of the following month. An employer that enrolls after the 15th will have their coverage effectuated on the first day of the next month. For example, an employer that enrolls on March 17th will have an effective date of May 1st. For special enrollment periods, the effectuation date will depend on the employee's specific situation. See 45 CFR § 155.420(d) of the HHS Final Exchange Establishment Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) for applicable employee circumstances. There are instances where the effective date of coverage will be retroactive. For example, the effective date for the birth or adoption of a child is always the date of the qualifying event, regardless of when an issuer is notified, and as long as the FF-SHOP is notified within 30 days of the event.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Initial Payment	**Q39:** Please confirm that issuers will not be required to effectuate coverage without payment.	**A39:** Issuers will not be required to effectuate coverage without payment. If an issuer has not received payment by the effectuation date, the issuer may send a cancellation notice to the FF-SHOP.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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IRS Reporting	**Q40:** The HHS Final Exchange Establishment Rule, 45 CFR § 155.720(i), requires the SHOP to report to the IRS employer participation, employer contribution, and employee enrollment information in a time and format to be determined by HHS. What information will issuers be required to report for purposes of employer contributions to the FF-SHOP and how will this information be collected?	**A40:** 45 CFR § 155.720(i) of the HHS Final Exchange Establishment Rule (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf) describes a reporting standard for SHOPs. This standard is limited to employers and does not include QHP issuers. All individuals providing health insurance, however, are subject to the standards for "Reporting Health Insurance Coverage" under 26 U.S.C. § 6055 (http://www.gpo.gov/fdsys/pkg/USCODE-2011-title26/pdf/USCODE-2011-title26-subtitleF-chap61-subchapA-partIII-subpartD-sec6055.pdf). The IRS will provide information regarding the implementation of these standards.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Employer Appeal of Termination for Non-payment of Initial Premium	**Q41:** Can CMS please clarify an employer's appeal right for a group terminated by the issuer for non-payment of the first month's premium?	**A41:** The FF-SHOP and Marketplace rules create no new appeal rights for an eligible employer who fails to make its first month's premium payment before the coverage effective date.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Summary of Benefits and Coverage	**Q42:** How will an issuer's Summary of Benefits and Coverage (SBC) be	**A42:** The FF-SHOPs will provide an online link to SBCs and plan brochures within the "plan comparison tools" if the QHP issuer submitted this	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	made available to the group' benefits administrator and to the group's members during FF-SHOP enrollment periods?	information on its QHP application.			
Dependent Coverage	**Q43:** How should issuers account for working Medicare eligibles and their dependents under the FF-SHOP employer groups? If dependents are eligible for coverage, how will the FF-SHOP report this membership to the health plans? Will they enroll the next oldest dependent as the subscriber, or will they report the Medicare member as a non-covered subscriber and enroll the dependents under the non-covered subscriber account?	**A43:** The FF-SHOP enrollment system only allows dependents to be covered if an employee is enrolled in the group plan. CMS will work with issuers to make necessary adjustments in the future.	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf
Renewals	**Q44:** When will subscriber rates be calculated? Will they be based on the age of an enrollee using	**A44:** Subscriber rates in the FF-SHOPs are calculated at the time of initial enrollment and upon renewal based on the coverage effective dates. Thus in the example above, the subscriber with an	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	the group's original effective date or will they be based on the age of a subscriber when they actually enroll? For example: One subscriber has a Date of Birth of July 18, 1967, and enrolls when the group initially enrolls on May 1st, 2013. For billing submitted to this subscriber on September 1, 2013, the subscriber would remain 45-years-old until May 1, 2014. Another subscriber has a Date of Birth of July 18, 1967 in the same SHOP group with an original effective date of coverage of August 1, 2013. For billing submitted to this subscriber on September 1, 2013, is the subscriber's age 45 or 46 until May 1, 2014?	effective date of August 1, 2013 will be billed using the per-member rate for a 46-year-old.			
Relationship Codes	**Q45:** What relationship codes will CMS send for	**A45:** CMS is using standard HIPAA relationship codes on ASC X12 834 enrollment transactions. If an issuer	FAQ August 28, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ4_082713_5CR_082813.pdf

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	enrollment transactions received via the FF-SHOP? The relationship codes listed in the ASC X12 834 implementation guide on the INS02 segment list include many that are not appropriate for single or family coverage.	does not accept certain relationship combinations in their plans, those relationships will not be sent to that issuer for enrollment. Issuers defined the relationships that are allowed within their QHPs at the time of QHP submission from the universe of permissible values.			
Transactions / Premium Payment / Enrollment	**Q1:** What happens when a cancellation occurs due to non-payment and the issuer receives the payment from the consumer after cancellation? Are issuers permitted to reinstate or will the enrollment need to come in again from FFE?	**A1:** Issuers may choose to cancel coverage of any qualified individual who does not make timely payment of the initial premium. If the individual submits payment after the cancellation has occurred, the issuer cannot reinstate the individual. If the qualified individual is still in an enrollment period at the time the coverage is cancelled, he or she may go through the plan selection process again and may select the same or another QHP, on or before the end of the enrollment period.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q2:** What information is passed to issuers if the customer does not sign up in the same session?	**A2:** If an individual does not make a selection of a QHP during a session on the Exchange, no information is provided to issuers.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q3:** Is there a list of definitions of all member and/or	**A3:** Information on the identifiers used in the transaction is provided in the CMS Companion Guide, which is	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	enrollment identifiers assigned through the enrollment cycle with the respective business rules / assumptions?	available on the CMS website at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf. Version			
Transactions / Premium Payment / Enrollment	**Q4:** Will issuers still send customers (consumers) premium invoices directly or will the Federal government collect premiums for individuals as well as SHOP business and send them to the health plan via the 820?	**A4:** In the first year of the FF-SHOP (2014), QHP issuers will be responsible for billing enrollees and employers to obtain required premium payments. The Federally-facilitated Exchange will not participate in the billing or collection of premiums. Beginning on or after January 1, 2015, the FF-SHOP will bill and collect premiums from the employer, and remit premiums to the appropriate issuers. The FF-SHOP will provide premium aggregation services to health plans via an electronic transaction, expected to be the ASC X12 Other Premium Payment 820 (Version 5010).	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q5:** Are issuers required to allow individuals to make partial payments on the first premium, where the member is redirected to the issuer site once enrollment has been completed? Are issuers required to	**A5:** Issuers may, but are not required to, allow individuals to make partial payments on the first month's premium. However, prior to the effective date of coverage, if the enrollee does not ultimately make full payment for their applicable portion of the first month's premium, the issuer must cancel coverage. An issuer may also accept partial payment for any subsequent month, but if the enrollee does not make	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	allow partial payments on subsequent payments following first premium?	full payment of their applicable portion of all premiums due before the end of the applicable grace period, the issuer must terminate coverage. If an individual is receiving APTC, he or she is only accountable for their portion of the premium for it to be considered a full payment. Therefore, if the individual has paid their share of the premium, the issuer may not wait until receiving the remainder from the federal government to maintain coverage.			
Transactions / Premium Payment / Enrollment	**Q6:** What are the requirements for how the (premium) payment is to be made (by check, credit card, etc.)?	**A6:** There are no regulatory requirements for how enrollees are to make their premium payments e.g. by paper, electronic or other means. However, in the April 2013 Letter to Issuers available on our website at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf, we state that QHP issuers should provide enrollees with information about how to make premium payments, and that they must be able to accept payment in ways that are not discriminatory.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q7:** What happens when the consumer is redirected to the issuer site to make the initial premium	**A7:** After an individual has made a plan selection, and is redirected to the issuer's website for instructions on how to make the first month's premium payment, there is no further role for the	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	payment and then decides not to make that payment? Is the Exchange out of the process at that point and issuers would start their normal billing process?	FFE. If an individual decides not to make the first month's premium payment on the website, the issuer may choose to bill the individual through their standard billing process.			
Transactions / Premium Payment / Enrollment	**Q8:** What would the consumer experience be if the consumer returned to the FFE website in an attempt to pay the initial premium?	**A8:** If an enrollee returned to the FFE website in an attempt to pay the initial month's premium, s/he would be re-directed to the QHP issuer site for instructions on making the payment, as the Exchange does not accept or arrange any payment between the enrollees and issuers.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q9:** Will the consumer be provided a confirmation email with additional plan information, such as a link to the issuer's website, after plan selection?	**A9:** Once an individual makes a QHP selection, s/he will be redirected to that QHP's website where additional information about how to make the initial month's premium payment will be available.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q10:** Will issuers be provided an enrollment start date and a subsequent termination date only when the record	**A10:** When an individual enrolls with the QHP issuer, the enrollment transaction will include an enrollment effective date, but the initial transaction does not include a coverage end date. When an individual's coverage ends, the	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	terminates (per request, non-payment or other)?	coverage termination date will be indicated in the 834 termination transaction. For the most current guidance on the enrollment transactions please refer to the CMS Companion Guide, available at: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/companion-guide-for-ffe-enrollment-transaction-v15.pdf.			
Transactions / Premium Payment / Enrollment	**Q11:** Will the same FFE identifier follow the member through the initial and any subsequent future enrollments?	**A11:** The member identifier will remain with an individual through the initial and subsequent enrollments as long as that individual remains in the same QHP. For example, an individual in an FFE selects a QHP issuer (issuer A). The individual is assigned an ID (1234) by the FFE. That ID will stay with the individual while he/she is enrolled with Issuer A. If the individual terminates with issuer A during annual open enrollment, and selects a different QHP issuer (issuer B) they will get a new ID (5678). Later, if for whatever reason, the individual terminates enrollment with issuer B and enrolls again with issuer A, he/she will be reassigned the same ID (1234) given during their first enrollment with issuer A.	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q12:** Will HHS be providing additional scenarios that show	**A12:** To help issuers understand how the Federally-facilitated Market place will operate, CMS has prepared written	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	the process flow if a customer exits the process before selecting a plan?	scenarios which describe enrollment related events such as initial enrollments, terminations, changes, and cancellations. Each scenario includes a narrative of the event and specific information about data that will be included in the 834 enrollment transaction. The scenarios have been shared with issuers during training webinars and other meetings, and will be useful in their Requirements, Design, Development and Training activities. At this time, we are updating existing scenarios. If we identify an enrollment-related situation that has significant business, policy or transactional conditions, we will consider creating a scenario to share with the issuers. The example in this question will be considered accordingly.			
Transactions / Premium Payment / Enrollment	**Q13:** In the individual Exchange, what details or data elements are issuers required to show on the premium billing invoice?	**A13:** There are no regulatory requirements governing the content of an issuer's premium billing invoice for enrollees of the individual exchange	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf
Transactions / Premium Payment / Enrollment	**Q14:** How do issuers communicate the inbound 834 rejects due to a failure on the issuers' side?	**A14:** The Exchange will be using several transactions to address 834 (enrollment transaction rejections). One transaction is the TA1 for file level errors; another is the ASC X12 999 for	FAQ April 24, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ1_042413_5CR_090413.pdf

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	How should issuers respond back to the Exchange to the inbound 834's with invalid email addresses?	functional group level errors (WEDI levels 1-6). A third transaction under consideration is the ASC X12 834 Application Advice for other errors (business logic edit failure). The process for communicating transaction errors using this third transaction (the X12 834) will likely require a separate companion guide for its use. Instructions for how issuers should communicate and respond to rejections will be provided soon. If provided by the individual during the application process, the FFE will provide up to 3 communication contacts (home phone, work phone, cell phone, and email address) in the initial 834 enrollment transaction. If the issuer feels the email address provided by the enrollee is invalid, the issuer may obtain an updated email address from the enrollee, and should advise the enrollee to provide the FFE with the updated address by logging into "My Account" on the FFE website.			
Tobacco Rating	**Q1:** If an employee or an employee's dependent obtaining coverage through the FF-SHOPs uses tobacco (as defined in 45 CFR 147.102(a)(1)(iv)), how can the employee or	**A1:** The FF-SHOPs will not impose the tobacco premium rating surcharge at the time of initial enrollment (or re-enrollment) if the employee or dependent, as applicable, agrees at the time of enrollment (or renewal or re-enrollment) to participate in a wellness program meeting the standards of section 2705 of the Public Health Service Act, such as a tobacco cessation	FAQ September 13, 2013	CMS	https://www.regtap.info/uploads/library/SHOP_FAQ5_091313_5CR_091313.pdf

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	dependent avoid the tobacco premium rating surcharge?	program.			
Tobacco Rating	**Q2:** If an employee or enrollee's dependent already enrolled in coverage through the FF-SHOPs decides to participate in a wellness program in the middle of a plan year after initially declining the offer of such enrollment, will his or her premium be reduced immediately or retroactively to the time of open enrollment?	**A2:** In the FF-SHOPs, an employee's or employee's dependent's premium will be established for a period of one year upon enrollment, renewal, or re-enrollment of that employee or dependent. At that time, the enrollee or dependent can agree to participate in a wellness program meeting the standards of section 2705 of the Public Health Service Act, such as a tobacco cessation program in order to avoid the tobacco premium surcharge. If the employee or dependent does not agree at that time to participate in such a wellness program, the employee or dependent will have an opportunity to avoid the tobacco premium surcharge upon renewal or reenrollment for subsequent coverage.	FAQ September 13, 2013	**CMS**	https://www.regtap.info/uploads/library/SHOP_FAQ5_091313_5CR_091313.pdf
Notice of Coverage Options Available Through the Exchanges/ 90-day Waiting Period Limitation	**Q1:** Is it permissible for another entity (such as an issuer, multiemployer plan, or third-party administrator) to send the Notice of Coverage Options on behalf of an employer to satisfy the employer's obligations under FLSA section 18B?	**A2:** Yes, an employer will have satisfied its obligation to provide the notice with respect to an individual if another party provides a timely and complete notice. The Department of Labor notes that, as explained in Technical Release 2013-02, FLSA section 18B requires employers to provide notice to all employees, regardless of whether an employee is enrolled in, or eligible for, coverage under a group health plan. Accordingly, an employer is not relieved of its	FAQ September 13, 2013	CMS	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs16.html

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		statutory obligation to provide notice under FLSA section 18B if another entity sends the notice to only participants enrolled in the plan, if some employees are not enrolled in the plan. When providing notices on behalf of employers, multiemployer plans, issuers, and third party administrators should take proper steps to ensure that a notice is provided to all employees regardless of plan enrollment, or communicate clearly to employers that the plan, issuer, or third party administrator will provide notice only to a subset of employees (e.g., employees enrolled in the plan) and advise of the residual obligations of employers with respect to other employees (e.g., employees who are not enrolled in the plan).			
Notice of Coverage Options Available Through the Exchanges/ 90-day Waiting Period Limitation	**Q2:** Will the Departments be issuing final regulations under PHS Act section 2708 that give plans and issuers sufficient time to comply with the waiting period limitation?	**A2:** Yes. As stated in the proposed rules, plans and issuers can rely on guidance provided in the March 2013 proposed rules at least through 2014. To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to January 1, 2015 and the Departments expect they will give plans and issuers sufficient time to comply. [5] Under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility	FAQ September 13, 2013	CMS	http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs16.html

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		provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation. Therefore, for example, if a multi employer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation).			
Employee Fines	**Q1:** Can an employer be fined for failing to provide employees with notice about the Affordable Care Act's new Health Insurance Marketplace?	**A1:** No. If your company is covered by the Fair Labor Standards Act, it should provide a written notice to its employees about the Health Insurance Marketplace by October 1, 2013, but there is no fine or penalty under the law for failing to provide the notice. The notice should inform employees: About the Health Insurance Marketplace; That, depending on their income and what coverage may be offered by the employer, they may be able to get lower		DOL	http://www.dol.gov/ebsa/faqs/faq-noticeofcoverageoptions.html

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		cost private insurance in the Marketplace; and That if they buy insurance through the Marketplace, they may lose the employer contribution (if any) to their health benefits			
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q1:** How is the relationship code for "ward" to be used to designate dependent and/or disabled status?	**A1:** Qualified individuals will select the term "ward" to designate a dependent and/or disabled relationship (within the family) when completing the eligibility application. When selected, this relationship code will be sent to the Qualified Health Plan (QHP) on the ASC X12 834 enrollment transaction. Note: CMS requested that QHP issuers add "ward" as an eligible dependent in their business rules to reflect the Federally-facilitated Marketplace (FFM) definition of disabled dependent.	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q2:** How should issuers handle over-aged disabled dependents who do not receive the proper health certification before choosing a Qualified Health Plan (QHP)? Some issuers have specific requirements for disabled dependents that were	**A2:** The Federally-facilitated Marketplace (FFM) does not require health certification for a disability as a condition of enrollment; therefore qualified individuals can be enrolled and designated as a disabled dependent without submitting documentation to the FFM. The QHP issuer should effectuate enrollment for all eligible individuals for whom the premium has been received. Any documentation required by issuers for certification of disability may be requested after effectuation.	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf

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	not captured by the business rules submitted during plan certification and plan preview.				
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q3:** Some enrollments that use the term "ward" to designate disabled dependent status, may not actually be disabled dependents. If an issuer is concerned that an enrollment is not accurate, how should the transaction be handled? How will issuers reconcile information with the Federally-facilitated Marketplace?	**A3:** Generally, if a qualified individual has designated a dependent as a ward, the issuer may assume the individual is eligible to enroll, and that s/he is a disabled dependent. However, issuer specific verification activities following enrollment are permissible. More information on processing inconsistencies in enrollment transactions will be forthcoming	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q4:** Generally, to be considered a disabled dependent, issuers require an individual to be disabled before age 26, have physician confirmation, and already be enrolled with a health plan. If an individual does	**A4:** Issuers should process the initial enrollment transaction received for the individual as a “ward,” and if the premium payment is received timely, effectuate the enrollment. If after enrolling the qualified individual who has been designated with the relationship code “ward,” the Qualified Health Plan (QHP) determines that the enrollee is not in fact a disabled dependent, then the QHP should follow	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf

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	not meet these requirements, they would not be on the same "contract" as the primary subscriber. How should issuers process an enrollment transaction with a "ward" enrollee who it (the issuer) determines does not meet their standard requirements for disabled dependent status? Should issuers process the enrollment transaction as a termination, cancellation or separate enrollment?	the process that the Marketplace will put in place for resolving discrepant data, including disputed relationship codes or enrollment groups.			
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q5:** Issuers want to use the disability flag to indicate a disabled dependent; and would rather use that flag than the code for "ward." Will the Federally-facilitated Marketplace (FFM) use the disability flag in the ASC X12 834	**A5:** No, the Federally-facilitated Marketplace (FFM) is not using the disability flag in the enrollment transaction. Issuers will need to acknowledge the term "ward" as the indicator of disabled dependent.	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf

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	enrollment transaction?				
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q6:** Does the Federally-facilitated Marketplace (FFM) apply age limits on dependents when forming enrollment groups?	A6: The Federally-facilitated Marketplace (FFM) applies the age limits submitted by issuers in the business rules section of the Qualified Health Plan (QHP) application for children of subscribers (the maximum age is at minimum 26, and higher for some states and issuers). The FFM does not apply age limits to dependents that are "wards."	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q7:** Why can't the disabled loop be used in the ASC X12 enrollment transaction?	**A7:** The Affordable Care Act limits the collection of information from applicants that is not directly related to determining eligibility. Detailed disability status questions such as those required to complete the disability information at INS10 in the 2200 Loop were not required to determine an applicant's eligibility and are therefore not collected.	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf
Disabled dependents, Wards and enrollment in the Federally-Facilitated Marketplace	**Q8:** Does "ward" (usage in the case of a disabled dependent) also apply to the SHOP market?	**A8:** Yes, the Federally-facilitated Marketplace (FFM) use of "ward" to identify disabled dependents applies to SHOP as well as the individual Marketplace.	FAQ September 19, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ8_DisabledDependentsWards_091913_5CR_091913.pdf
Policy and Technical Questions	**Q1:** If an individual forgoes using the payment redirect	**A1:** Yes, if an individual has confirmed a Qualified Health Plan (QHP) selection on the Federally-facilitated Marketplace	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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	session with the Qualified Health Plan (QHP) before completing the payment process, does the ASC X12 834 enrollment transaction continue from the Federally-facilitated Marketplace (FFM) to the QHP issuer for that individual?	(FFM) site the FFM will always transmit the individual's choice to the QHP in the daily enrollment transaction regardless of whether the individual did not complete the online payment process via the redirect process,. The issuer can use the enrollment transaction information to generate a premium bill for enrollees who have not yet made their first premium payment.			
Policy and Technical Questions	**Q2:** If there are changes after the initial enrollment (e.g., adding a dependent), will all the subsequent enrollment changes have the same Payment Transaction ID?	**A2:** Premium redirect only occurs for the initial premium payment. Therefore, any changes subsequent to the initial effectuated enrollment will not have a Payment Transaction ID because the payment redirect process will not be activated. The issuer will need to generate a new premium bill for the individual or family.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q3:** If the individual changes their mind and does not want to enroll in the Qualified Health Plan (QHP) they chose, even after they've taken all of the steps to enroll,	A3: No. The Qualified Health Plan (QHP) cannot "stop" the enrollment. If the individual chooses to make a new selection during a valid enrollment period and before coverage for the original selection begins, s/he can make a new selection via the Federally-facilitated Marketplace (FFM). The FFM will send the new ASC X12 834	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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	can the QHP stop the enrollment?	enrollment transaction to the new QHP issuer, and an ASC X12 834 cancellation to the original issuer. The new issuer will receive a transaction with a new Payment Transaction ID.			
Policy and Technical Questions	**Q4:** Can an individual be prevented from making changes to their initial selection until the first Qualified Health Plan (QHP) issuer has collected payment and sent the confirmation back to the Federally-facilitated Marketplace (FFM)?	**A4:** No. Changes cannot be held until the issuer has collected payment. In a scenario where a qualified individual changes his/her original QHP selection during a valid enrollment period, the Federally-facilitated Marketplace (FFM) will provide the QI the payment redirect URL for the new QHP and assign a new Payment Transaction ID. The FFM will send an ASC X12 cancellation transaction to the "losing" QHP, and will create a new initial ASC X12 834 enrollment transaction for the new QHP selected.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q5:** What will a Small Business Health Options Program (SHOP) employer see on the issuer website if they are not paying premiums online?	**A5:** A SHOP employer will see summary text describing what the employer can expect next, which includes receipt of an invoice or bill from the issuer.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q6:** What if an issuer has two pathways for collection of the initial premium	A6: In the scenario described, the issuers would have submitted their URL for payment redirect for individual products in the Qualified Health Plan	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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	payment? For example, an issuer has contracted with a Third Party Administrator (TPA) to collect initial premium payments for the individual market, but for the SHOP, this service is out of scope. Some issuers are planning to collect the initial premium for SHOP using a different process. How will two different processes work with premium payment redirect?	(QHP) application but left the payment redirect question for SHOP products blank. When confirming selections via the FFM, individuals who enroll in the individual market QHP will find the URL for the payment redirect process, and the SHOP employers will be informed that they will receive a bill from the issuer.			
Policy and Technical Questions	**Q7:** In the XML file that is sent to the issuer at the time of the payment redirect, what delimiter will be used to separate member names in the "Additional Information" field?	**A7:** The XML file will include the semicolon (;) as the delimiter used to separate member names in the Additional Information field.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q8:** Is the Payment Transaction ID being supplied for each	**A8:** Yes. The Payment Transaction ID is included for each payment instance for each enrollment group. For a	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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	payment instance?	detailed description, refer to the June 2013 updated Payment Redirect Business Service Description (BSD), which also includes several scenarios. The BSD is available on the zone (https://zone.cms.gov/) and on the REGTAP site at www. REGTAP.Info			
Policy and Technical Questions	**Q9:** If an individual selects a medical and dental QHP from the same issuer, and the information is on a different 2000 loop in the ASC X12 834 enrollment transaction, is the premium amount owed going to total up to one amount and we only enroll the individual if the total (premium) amount is received?	**A9:** No. Each QHP selection – medical and dental - will generate a separate enrollment and a separate payment Transaction ID. If a family selects a medical QHP and a separate dental QHP under the same issuer, the enrollments will be separate. The enrollee will be redirected once to the URL for the medical plan and then a separately to the URL for the dental plan. Issuers are expected to effectuate each enrollment independently once payment for the respective QHP selection is received.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q10:** How can there be two redirects - one for medical and one for dental? How will this process flow?	**A10:** There will be a redirect for each type of plan selection. For example, if an individual selects a medical plan and a dental plan, they will be redirected to two different locations on the issuer's website. The consumer will access the payment redirect web links from the FFM website on the plan summary page presented after s/he has confirmed the	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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		plan selections. For each online payment, the consumer is redirected via a new window.			
Policy and Technical Questions	**Q11:** If an individual changes to a different Qualified Health Plans (QHP) before enrollment in one is effectuated, will they be redirected to the new QHP issuer's website to make the first premium payment?	**A11:** Yes. If an individual selects a new Qualified Health Plan (QHP) before their original selection has been effectuated, s/he would receive a new Payment Transaction ID and be redirected to the new qualified health plan's website through the payment redirect process.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q12:** How often will individuals be able to use the payment redirect process? Will they be redirected every time they make a change to a new Qualified Health Plan (QHP)?	**A12:** Qualified Individuals will use the redirect function if they chose another QHP during an open enrollment or Special Enrollment Period. The payment redirect process is not used within the same QHP when other types of enrollment related changes are made after coverage has been effectuated.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q13:** Are there documents that provide examples of specific actions that will or will not trigger the payment redirect process?	**A13:** Yes. The most current Payment Redirect Business Service Description (BSD), published in June 2013, provides several examples of triggers for the premium payment redirect process. You may find the BSD on the zONE, the collaboration site for technical documents (https://zone.cms.gov/). A copy is also	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf

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		available on the public facing site REGTAP, www. REGTAP.info .			
Policy and Technical Questions	**Q14:** If the qualified individual comes back to make a premium payment on the issuer's website for a Qualified Health Plan (QHP) enrollment initiated on the FFM, what will happen to the Payment Transaction ID?	**A14:** If a qualified individual visits the Qualified Health Plan (QHP) website independently once enrollment is complete, the payment transaction ID is no longer relevant. Once the individual has been able to enroll in the QHP, makes the initial premium payment and has the enrollment confirmed, there is no further need for the payment transaction ID.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Policy and Technical Questions	**Q15:** For SHOP, will there be a Payment Transaction ID on the Employer Group Enrollment transaction?	**A15:** Yes, the Payment Transaction ID has been added to the Employer Group Enrollment XML file format, in version 13. This was posted on the CMSzONE on June 17, 2013.	FAQ September 17, 2013	CMS	https://www.regtap.info/uploads/library/EE_FAQ7_PaymentRedirect_5CR_091713.pdf
Operational Tips for Completing Agent/Broker Registration for the Federally-facilitated Marketplaces (FFM)	**Q1:** How do agents/brokers register for the FFM?	**A1:** To the extent permitted by the licensing state, agents and brokers may assist in enrolling individuals in qualified health plans (QHP) in the FFM Individual Marketplaces, provided they complete the following steps: • Part I: Register on the Medicare Learning Network (MLN)®, complete assigned training and exams, and execute the Federally-facilitated Marketplace Agreements. This can be	FAQ September 17, 2013	CMS	

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		accessed at https://marketplace.medicarelearningnetworklms.com/ -You will need to enter basic identifying information, including your National Producer Number (NPN), as prompted. It is vital that you enter your NPN correctly and that you remember your MLN user ID. When you enter your NPN, use numeric digits only and do not include leading zeroes or hyphens. (Your NPN must be 10 digits or less.) -Keep the training curriculum certificates you receive. You will need to provide copies of your curriculum certificates to the issuers and web-brokers with which you are affiliated. You will receive a certificate for each curriculum you complete successfully. -After you complete training, please allow 48 business hours to elapse before you attempt to access the identity proofing process—this will better ensure that your training records have been fully transmitted to the CMS Enterprise Portal. https://Marketplace.MedicareLearningNetworkLMS.com.			
Operational Tips for Completing Agent/Broker Registration for the	**Q2:** Is there a **deadline** to complete the agent/broker registration with the FFMs?	**A2:** There is no calendar deadline to complete registration requirements for the FFM. However, the Marketplace-specific requirements must be met before assisting qualified individuals,	FAQ September 17, 2013	CMS	

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Federally-facilitated Marketplaces (FFM)		employers, and employees with eligibility and enrollment determinations for the 2014 plan year. Open enrollment for the 2014 plan year begins on October 1, 2013. In states where an FFM is operating, all agents and brokers must register with the FFM before assisting qualified individuals to select Individual Marketplace coverage for the 2014 plan year.			
Operational Tips for Completing Agent/Broker Registration for the Federally-facilitated Marketplaces (FFM)	**Q3:** If I have **more than one NPN**, which NPN should I use when I register? How are **corporate NPN**s registered for the FFMs?	**A3:** If an entity has a corporate National Producer Number (NPN), that NPN should be registered with the Federally-facilitated Marketplaces (FFM), based on the steps described below. In addition, each individual agent should register with the FFM using their individual NPN. Prior to assisting consumers, each agent or broker needs to have completed the FFM training and registration process. For most agents and brokers, the registration process for the Federally-facilitated Marketplaces will consist of two parts. Part I includes training, exams, and the electronic signing of Federally-facilitated Marketplace Agreements. Part I occurs on the Medicare Learning Network (MLN)®, and can be accessed at https://Marketplace.MedicareLearningNetworkLMS.com. Part II includes identity proofing and the creation of an FFM User ID. Part II occurs on the CMS Enterprise Portal,	FAQ September 17, 2013	CMS	

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		which can be accessed at https://portal.cms.gov/. (Please be advised: Agents and brokers who want to operate exclusively within the Federally-facilitated Small Business Health Insurance Options Program (FF-SHOP) Marketplaces are strongly encouraged to complete Marketplace-specific training courses and pass the accompanying exams, and they are required to electronically sign the Federally-facilitated SHOP Marketplace Agreement. They are not required to complete Part II of the registration process.) Below is information about entering your NPN during the FFM registration process. For Part I of the FFM registration process: • It is vital that you enter your NPN correctly in your MLN profile. Do not add any leading zeroes. • If you have multiple NPNs—for example, if you are an agent/broker who is licensed as an individual and you also own a business entity that has a separate NPN—you must create a separate MLN account for each NPN and you must complete the required 3 training for each MLN account/NPN. • For business entities that wish to register and participate in the FFM, the business entity must select an authorized			

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		official to complete the required training on MLN using the NPN of the corporate entity. For example, the business entity may select the president or the CEO to complete the MLN training, using the business entity's NPN. (Remember, however—in addition to the business entity registering, each individual agent should register with the FFM using their individual NPN. Prior to assisting consumers, each agent or broker needs to have completed the FFM training and registration process.) • Remember, all compensation arrangements must be made directly with the issuers or web-brokers with whom you are affiliated. For Part II of the FFM registration process: • It is vital that you enter your NPN and your MLN user ID correctly in Part II. Do not add any leading zeroes to your NPN. • If you have multiple NPNs: During Part II of the registration process, you should enter the NPN that you anticipate will be included on the majority of the QHP enrollment applications you assist with. In other words, enter the NPN under which you expect to conduct the majority of your FFM business. You will need to enter the MLN user ID that is associated with that NPN. You will only complete Part II identity			

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		verification for one of your NPNs; you will not complete identity verification for each of your NPNs. • In the case of business entities, the authorized official who completed the MLN training with the NPN of the corporate entity is the individual who must complete Part II of the registration process. When completing Part II, the authorized official should again enter the NPN of the corporate entity, and the MLN user ID that is associated with that account.			
Operational Tips for Completing Agent/Broker Registration for the Federally-facilitated Marketplaces (FFM)	**Q4:** How do I know what my **NPN** is? Where can I find my NPN?	**A4:** National Producer Numbers (NPN) are managed and controlled by the National Insurance Producer Registry (NIPR). Your NPN is an up to 10-digit number, without leading zeros. An NPN is a unique sequential number used to identify individual producers. If you are unable to recall your NPN, you may obtain it by visiting https://pdb.nipr.com/html/PacNpnSearch.html. It is vital that you enter your NPN correctly when you are registering for the FFM. Do not enter leading zeroes, and do not enter hyphens.	FAQ September 17, 2013	CMS	
Operational Tips for Completing Agent/Broker Registration for the Federally-facilitated	**Q5:** Where can I get **more information** about being an agent/broker in the FFM?	**A5:** To learn more about being an agent or broker in the FFM, please visit: • http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/assistance.html	FAQ September 17, 2013	CMS	

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Marketplaces (FFM)		and • http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/a-b-resources.html. There are a number of links and documents on those pages which will help you to learn more about the roles of agents and brokers in the FFM.			
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q6:** What is the **URL** to complete the agent/broker training ("Part I")?	**A6:** Agent/broker training for the FFMs is located on the Medicare Learning Network. The URL is: https://Marketplace.MedicareLearningNetworkLMS.com	FAQ September 17, 2013	CMS	
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q7:** How do I **reset my password**/username on the MLN site?	**A7:** Click the "Forgot your login ID?" and "Forgot your password?" links on the login page of Medicare Learning Network ® (MLN).	FAQ September 17, 2013	CMS	
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q8:** Can I take the agent/broker courses on my iPad? Can I take the agent/broker courses on my phone? Can I take the agent/broker courses on my **handheld device**?	**A8:** The agent/broker training courses for the Federally-facilitated Marketplaces (FFM) are not currently compatible with iPads or handheld devices.	FAQ September 17, 2013	CMS	

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AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q9:** I'm an agent/broker, and I'm trying to set up my account on MLN, to take training. What should I enter in the **organization fields**?	**A9:** As you set up your MLN account, you will see that there are two fields displayed that relate to organization information. It is very important that you select your appropriate User Type/User Role before you enter any organization information. As an agent or broker, you should select one of the three agent/broker User Roles, based on the insurance market(s) you wish to serve. After you select the appropriate agent/broker User Type/User Role, you will see that the first field, labeled "Organization Type" is automatically grayed-out, because it is not a field that agents/brokers need to complete. You will not be able to enter text in the "Organization Type" field. The second field, labeled "Organization," is a required field for agents/brokers. Next to the "Organization" field, please click on the blue text that says "Select". A new screen will pop up. When that next screen appears, click the gray "Search" button, and the Organization named "Marketplace" will appear as the only option. Please click the circle to select Marketplace, select "Save," and you will then be returned to the previous screen, where you can finish creating your MLN account.	FAQ September 17, 2013	CMS	
AGENT/BROKER TRAINING	**Q10:** I took an exam, but I **didn't get a**	**A10:** To successfully complete the training requirements, you must register	FAQ September 17, 2013	CMS	

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(PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**curriculum certificate**. How do I get a curriculum certificate?	for a curriculum on the MLN website, rather than for individual courses. If you register only for individual courses, you will not earn the curriculum completion status that is required.			
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q11:** I'm having **technical problems viewing the training content**, or getting the MLN site to display properly.	**A11:** Below are some pointers that have enabled many other users to complete the training. If you are having problems accessing the training, we recommend you address each of these pointers. • Pop-up blockers—This setting must be turned off. • Cookie settings—Be sure to allow cookies. Some users' company network settings or individual computer settings are not set to allow cookies, and this has caused problems for them. • FlashPlayer—Be sure this is installed on your computer. The Marketplace training requires FlashPlayer; it can be downloaded at • Browser—Courses and exams do not run well on Internet Explorer 10, Google Chrome, or Firefox. The Marketplace training is optimized on Internet Explorer 8 or 9. • Physical Computer—The Marketplace training cannot be accessed on a tablet or other hand-held/mobile device, so you must use a desktop or laptop computer. • Bandwidth or servers issues—Check with your network provider for more assistance. Some users have encountered bandwidth and server	FAQ September 17, 2013	CMS	

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		issues related to the settings on their computer or on their company's network. http://get.adobe.com/flashplayer/. Q12:			
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q12:** How do I **print my training certificates** on MLN?	**A12:** Please note that the only certificate(s) that should be printed are those listed as type = "Curriculum." Disregard certificates listed as type = "SCORM 1.2." You only need to provide the curriculum certificates to the issuers. The curriculum certificates typically generate in HTML format. To save a copy to your computer we recommend that you either: 1. Click the "print" link at the top of the certificate screen and select "Microsoft XPS Document Writer" in your print options, or 2. Click the "print" link at the top of the certificate screen and select "Adobe PDF" (if you have Adobe Acrobat installed on your machine), or 3. Use the print screen function and paste the image into a Microsoft Word document. The print screen button (PrtScn) is located on the top row or two of your keyboard—usually near the number key pad on the right of the keyboard. After you have your certificate open, press the print screen button. Nothing obvious will occur. Go to your Word document, right click, and click "paste" in order to paste the image	FAQ September 17, 2013	CMS	

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		of your certificate into the Word document. If none of these three options work on your computer, the issue relates to your computer's individual settings, browser settings, and/or your network's settings. We suggest that you try to print your certificate from a different computer. Alternately, you may choose to ask your network administrator or a colleague for help with your computer/network settings, or you may contact the help line of the company from whom you purchased your computer. Please understand that CMS is unable to provide each individual agent or broker with a copy of their training curriculum certificate(s).			
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q13:** Can I get a **PDF version** of the agent/broker training? Can I download the agent/broker training?	**A13:** At this time, CMS does not have a copy of the agent/broker training available in downloadable format. However, a summary of the training is available on the CMS website: website: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/agent-broker-ffm-training-summary.pdf.	FAQ September 17, 2013	CMS	
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON	Q14: Can you provide me with my **MLN number**?	A14: There is no Medicare Learning Network (MLN)® number. You will create an MLN User ID when you	FAQ September 17, 2013	CMS	

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MEDICARE LEARNING NETWORK)	Where do I find my MLN number?	complete the training in Part I. You will have to use your MLN User ID, and the National Producer Number (NPN) that you used to register on the MLN site, to create a Federally-facilitated Marketplace (FFM) user account and complete identity verification on the CMS Enterprise Portal.			
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q15:** When will the MLN site assign me my **FFM registration number**?	**A15:** There are no "FFM registration numbers," and you will not be assigned an FFM registration number. You will create your FFM User ID when you create your account on the CMS Enterprise Portal during Part II of the agent/broker registration process.	FAQ September 17, 2013	CMS	
AGENT/BROKER TRAINING (PART I OF FFM REGISTRATION, ON MEDICARE LEARNING NETWORK)	**Q16:** I can't access **Part II** of the FFM registration process on the MLN site.	**A16:** Part II of the agent/broker registration process is available on the CMS Enterprise Portal: https://portal.cms.gov/.	FAQ September 17, 2013	CMS	
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q17:** What is the **URL** to complete the agent/broker identity proofing and set up an FFM account ("Part II")?	**A17:** To set up an FFM account and complete identity proofing, visit the CMS Enterprise Portal: https://portal.cms.gov/.	FAQ September 17, 2013	CMS	
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q18:** How do I **reset my password**/username on the CMS Enterprise Portal?	**A18:** To recover your User ID or password information, click on the "Forgot my User ID/Password" link on the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal log-in web page at https://portal.cms.gov/. Clicking this link will provide you with instructions for how to recover your	FAQ September 17, 2013	CMS	

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		User ID or initiate a password reset.			
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q19:** I have been unable to request access under the **FFM Agent Broker role** on the CMS Enterprise Portal. When I go to the page to add a role under the FFM, "FFM Agent Broker" role is not a choice.	**A19:** Agents and brokers who are using the CMS Enterprise Portal to create a Federally-facilitated Marketplace (FFM) user account and complete identity proofing should select "FFM—FFM Application" next to "Application Description" on the "My Access—Request New Application Access" page. You will then be prompted to make a selection next to "Role." You should select "FFM Agent Broker." There is no additional role that needs to be added once you have made this selection and completed identity proofing. Identity proofing includes accurately entering your Medicare Learning Network (MLN) user ID and NPN, and going through identity proofing by entering identifying information and answering "Out-of-Wallet" questions. If you have previously established an account through the CMS Enterprise Portal, please follow these steps: 1. To add the "FFM Agent Broker" role, make sure you select "Request Access Now" on the right side of the window after logging in to the CMS Enterprise Portal. 2. A new page will appear. Select "Request New Application Access" on the left side, under "My Access." 3. You should then select "FFM—FFM Application" from the drop-down list next to "Application Description."	FAQ September 17, 2013	CMS	

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		4. You will then be prompted to make a selection next to "Role". You should select "FFM Agent Broker." Please note: "FFM Agent Broker" is the only role that needs to be added, and you will not see this role reappear after you have accessed it.			
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q20:** I completed the training in Part I, but when I try to do identity proofing in Part II, I am getting an **error message that my information cannot be verified**. I am not sure how to fill out the **screen that is asking for my MLN user ID and my NPN**.	**A20:** After you complete training, please allow 48 business hours to elapse before you attempt to access the identity proofing process—this will help to ensure that your training records have been fully transmitted to the CMS Enterprise Portal. • You created your MLN user ID when you completed the training during Part I on the Medicare Learning Network (MLN)®. If you can't recall your MLN user ID, return to the MLN website (https://Marketplace.MedicareLearningNetworkLMS.com) and click the "Forgot your login ID?" link on the login page. • When you enter your NPN during Part II on the CMS Enterprise Portal, it should not be more than 10 numeric digits. It may be less than 10 digits. • During Part II on the CMS Enterprise Portal, enter your NPN the same way that you entered it in your MLN profile for Part I. However, do not use any hyphens or any letters in your NPN when you enter it during Part II on the CMS Enterprise Portal. Do not add	FAQ September 17, 2013	CMS	

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		leading zeroes. • If you cannot recall how you entered your NPN in your MLN profile, you may return to the MLN website, log in, and locate your name at the top right corner of the page. Click your name, and a drop-down list will appear. Select "My Account". The NPN that you completed training with should appear in your profile.			
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q21:** How do I know when I have **completed my registration** on the CMS Enterprise Portal?	**A21:** When you successfully complete the identity proofing in Part II, you will see the following screen message, which is titled Request Acknowledgement. The screen message states: "Your request has been successfully completed. You will need to logout and then log back on to access the FFM Application. Select 'OK' to continue." When you see this screen message, you have successfully completed the identity proofing process. To the degree permitted by state law, you will be able to provide assistance in the Federally-facilitated Marketplace when open enrollment begins this fall.	FAQ September 17, 2013	CMS	
AGENT/BROKER IDENTITY PROOFING (PART II OF FFM REGISTRATION, ON CMS ENTERPRISE PORTAL)	**Q22:** When will I receive my **FFM registration number**? When will I be assigned my FFM number?	**A22:** There are no "FFM registration numbers" and you will not be assigned an FFM registration number. You created your FFM User ID when you created your account on the CMS Enterprise Portal during Part II of the agent/broker registration process. If you have forgotten your FFM User ID or	FAQ September 17, 2013	CMS	

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		password information, click on the "Forgot my User ID/Password" link on the CMS Enterprise Portal log-in web page at https://portal.cms.gov/.			
Notice of Coverage Options Available Through the Exchanges	**Q1:** Is it permissible for another entity (such as an issuer, multiemployer plan, or third-party administrator) to send the Notice of Coverage Options on behalf of an employer to satisfy the employer's obligations under FLSA section 18B?	**A1:** Yes, an employer will have satisfied its obligation to provide the notice with respect to an individual if another party provides a timely and complete notice. The Department of Labor notes that, as explained in Technical Release 2013-02, FLSA section 18B requires employers to provide notice to all employees, regardless of whether an employee is enrolled in, or eligible for, coverage under a group health plan. Accordingly, an employer is not relieved of its statutory obligation to provide notice under FLSA section 18B if another entity sends the notice to only participants enrolled in the plan, if some employees are not enrolled in the plan. When providing notices on behalf of employers, multiemployer plans, issuers, and third party administrators should take proper steps to ensure that a notice is provided to all employees regardless of plan enrollment, or communicate clearly to employers that the plan, issuer, or third party administrator will provide notice only to a subset of employees (e.g., employees enrolled in the plan) and advise of the residual obligations of employers with respect to other employees (e.g.,	FAQ September 17, 2013	DOL	http://www.dol.gov/ebsa/faqs/faq-aca16.html

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		employees who are not enrolled in the plan).			
Notice of Coverage Options Available Through the Exchanges	**Q2:** Will the Departments be issuing final regulations under PHS Act section 2708 that give plans and issuers sufficient time to comply with the waiting period limitation?	**A2:** Yes. As stated in the proposed rules, plans and issuers can rely on guidance provided in the March 2013 proposed rules at least through 2014. To the extent final regulations are more restrictive on plans or issuers than the proposed regulations, they will not be effective prior to January 1, 2015 and the Departments expect they will give plans and issuers sufficient time to comply.[5] Under the proposed rules, to the extent plans and issuers impose substantive eligibility requirements not based solely on the lapse of time, these eligibility provisions are permitted if they are not designed to avoid compliance with the 90-day waiting period limitation. Therefore, for example, if a multiemployer plan operating pursuant to an arms-length collective bargaining agreement has an eligibility provision that allows employees to become eligible for coverage by working hours of covered employment across multiple contributing employers (which often aggregates hours by calendar quarter and then permits coverage to extend for the next full calendar quarter, regardless of whether an employee has terminated employment), the Departments would	FAQ September 17, 2013	DOL	http://www.dol.gov/ebsa/faqs/faq-aca16.html

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		consider that provision designed to accommodate a unique operating structure, (and, therefore, not designed to avoid compliance with the 90-day waiting period limitation).			
Premium Tax Credit	**Q1.** What is the premium tax credit?	**A1:** The premium tax credit is an advanceable, refundable tax credit designed to help eligible individuals and families with low or moderate income afford health insurance purchased through the Health Insurance Marketplace, also known as the Exchange, beginning in 2014. You can choose to have the credit paid in advance to your insurance company to lower what you pay for your monthly premiums, or you can claim all of the credit when you file your tax return for the year. If you choose to have the credit paid in advance, you will reconcile the amount paid in advance with the actual credit you compute when you file your tax return.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Premium Tax Credit	**Q2:** What is the Health Insurance Marketplace	**A2:** The Health Insurance Marketplace, also known as the Exchange, is the place where you will find information about private health insurance options, purchase health insurance, and obtain help with premiums and out-of-pocket costs if you are eligible. Open enrollment to purchase health insurance for 2014 through the Marketplace begins Oct. 1, 2013, and continues		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		through March 31, 2014. The Department of Health and Human Services (HHS) administers the requirements for the Marketplace and the health plans offered. Learn more about the Marketplace at HealthCare.gov.			
Premium Tax Credit	**Q3.** How do I get the premium tax credit?	**A3:** When you apply for coverage in the Marketplace, the Marketplace will estimate the amount of the premium tax credit that you may be able to claim for the tax year, using information you provide about your family composition and projected household income. Based upon that estimate, you can decide if you want to have all, some, or none of your estimated credit paid in advance directly to your insurance company to be applied to your monthly premiums. If you choose to have all or some of your credit paid in advance, you will be required to reconcile on your income tax return the amount of advance payments that the government sent on your behalf with the premium tax credit that you may claim based on your actual household income and family size. If you do not opt for advance credit payments, you may claim the credit when you file your tax return for the year, which will either lower the amount of taxes owed on that return or increase your refund.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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Premium Tax Credit	**Q4.** What happens if my income or family size changes during the year?	A4: The actual premium tax credit for the year will differ from the advance credit amount estimated by the Marketplace if your family size and household income as estimated at the time of enrollment are different from the family size and household income you report on your return. The more your family size or household income differs from the Marketplace estimates used to compute your advance credit payments, the more significant the difference will be between your advance credit payments and your actual credit. If your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain caps, will be subtracted from your refund or added to your balance due. If your actual allowable credit is more than your advance credit payments, the difference will be added to your refund or subtracted from your balance due. Notifying the Marketplace about changes in circumstances will allow the Marketplace to update the information used to determine your expected amount of the premium tax credit and adjust your advance payment amount. This adjustment will decrease the likelihood of a significant difference between your advance credit payments and your actual premium tax credit. Changes in		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		circumstances that can affect the amount of your actual premium tax credit include: • Increases or decreases in your household income. • Marriage. • Divorce. • Birth or adoption of a child. • Other changes to your household composition. • Gaining or losing eligibility for government sponsored or employer sponsored health care coverage.			
Eligibility	**Q5.** Who is eligible for the premium tax credit?	**A5:** You are eligible for the premium tax credit if you meet all of the following requirements: • Purchase coverage through the Marketplace. • Have household income that falls within a certain range (see question 6). • Are not able to get affordable coverage through an eligible employer plan that provides minimum value (see questions 8 and 9). • Are not eligible for coverage through a government program, like Medicaid, Medicare, CHIP or TRICARE. • File a joint return, if married. • Cannot be claimed as a dependent by another person.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Eligibility	**Q6.** What are the income limits?	**A6:** In general, individuals and families whose household income for the year is		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		between 100 percent and 400 percent of the federal poverty line for their family size may be eligible for the premium tax credit. An individual who meets these income requirements must also meet the other eligibility criteria described in question 5. Thus, if you have household income between 100 percent and 400 percent of the federal poverty line, but are eligible for coverage through your state's Medicaid program (for example, because your state provides Medicaid to individuals with household income up to 133 percent of the federal poverty line), you are not eligible for the premium tax credit. For 2013, for residents of one of the 48 contiguous states or Washington, D.C., the following illustrates when household income would be between 100 percent and 400 percent of the federal poverty line: • $11,490 (100%) up to $45,960 (400%) for one individual. • $15,510 (100%) up to $62,040 (400%) for a family of two. • $23,550 (100%) up to $94,200 (400%) for a family of four. Note: The federal poverty guidelines — sometimes referred to as the "federal poverty line" or FPL — state an income amount considered poverty level for the year, adjusted for family size. HHS determines the federal poverty guideline			

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		amounts annually. The government adjusts the income limits annually for inflation. The Federal Register publishes a chart reflecting these amounts at the beginning of each calendar year. You can also find this information on the HHS website. HHS provides three federal poverty guidelines: one for residents of the 48 contiguous states and D.C., one for Alaska residents and one for Hawaii residents. For purposes of the premium tax credit, eligibility for a certain year is based on the most recently published set of poverty guidelines at the time of the first day of the annual open enrollment period. As a result, the tax credit for 2014 will be based on the 2013 guidelines.			

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Eligibility	**Q7.** What is household income?	**Q8:** For purposes of the premium tax credit, your household income is your modified adjusted gross income plus that of every other individual in your family for whom you can properly claim a personal exemption deduction and who is required to file a federal income tax return. Modified adjusted gross income is the adjusted gross income on your federal income tax return plus any excluded foreign income, nontaxable Social Security benefits (including tier 1 railroad retirement benefits), and tax-exempt interest received or accrued during the taxable year. It does not include Supplemental Security Income (SSI).		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Eligibility	**Q8.** How do I know if the insurance offered by my employer is affordable?	**A8:** An employer-sponsored plan is affordable if the portion of the annual premium you must pay for self-only coverage does not exceed 9.5 percent of your household income. (See question 7 for what is included in household income.) The affordability test applies only to the portion of the annual premiums for self-only coverage and does not include any additional cost for family coverage. If the employer offers multiple health coverage options, the affordability test applies to the lowest-cost option available to you that also satisfies the minimum value requirement. If your employer offers any wellness programs, the affordability		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		test is based on the premium you would pay if you received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.			
Eligibility	**Q9.** How do I know if the insurance offered by my employer provides minimum value?	**A9:** An employer-sponsored plan provides minimum value if the plan covers at least 60 percent of the expected total allowed costs for covered services. Beginning in 2014, your employer will provide you with a document called a Summary of Benefits and Coverage. That document will give you information about the benefits and coverage under your employer-sponsored plan, including whether the plan provides minimum value. Also, under the Fair Labor Standards Act, most employers will provide employees with a notice about their options in the Marketplace and their potential eligibility for a premium tax credit. This one-time notice will include information about whether the employer has a plan that provides minimum value.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Eligibility	**Q10.** Am I eligible for the premium tax credit if I enroll in coverage through an employer?	**A10:** If you enroll in an employer-sponsored plan, you are not eligible for the premium tax credit even if the plan is unaffordable or fails to provide minimum value.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Reporting and Claiming	**Q11.** Will I have to file a federal income tax return to get the premium tax credit?	**A11:** For any tax year, if you receive advance credit payments in any amount or if you plan to claim the premium tax credit, you must file a federal income		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		tax return for that year. If you receive any advance credit payments, you will use your return to reconcile the difference between the advance credit payments made on your behalf and the actual amount of the credit that you may claim. This filing requirement applies whether or not you would otherwise be required to file a return. If you are married, you must file a joint return to be eligible for the premium tax credit.			
Reporting and Claiming	**Q12.** If I get insurance through the Marketplace, how will I know what to report on my federal tax return?	**A12:** The Marketplace will send you an information statement showing the amount of your premiums and advance credit payments by January 31 of the year following the year of coverage. For example, you will receive the 2014 information statement by Jan. 31, 2015, and can use this information to compute your premium tax credit on your 2014 tax return and to reconcile the advance credit payments made on your behalf with the amount of the actual premium tax credit.		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit
Reporting and Claiming	**Q13.** How is the amount of the premium tax credit determined?	**A13:** The law bases the size of your premium tax credit on a sliding scale. Those who have a lower income get a larger credit to help cover the cost of their insurance. In other words, the higher your income, the lower the amount of your credit. Additionally, the premium tax credit is a refundable tax credit. This means that if		IRS	http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-the-Premium-Tax-Credit

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		the amount of the credit is more than the amount of your tax liability, you will receive the difference as a refund. If you owe no tax, you can get the full amount of the credit as a refund. However, if you receive advance payments of the credit, you will reconcile the advance payments with the amount of the actual premium tax credit that you calculate on your tax return. If your actual allowable credit on your return is less than your advance credit payments, the difference, subject to certain caps, will be subtracted from your refund or added to your balance due. If your actual allowable credit is more than your advance credit payments, the difference will be added to your refund or subtracted from your balance due. (See question 4 for information on changes in circumstances.)			

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