2023PY QHP Issuer Submission Guide FAQs

Q. What constitutes an error? For example, would the OSI consider an objection an error and consequently assess a penalty per objection?
A. An example of an error is unintentional or inconsistent information between a PBT template in a binder and an SBC in an approved form/rate filing.

Q. What is the Transparency in Coverage template submission due date?
A. The Transparency in Coverage Template must be uploaded under the Templates tab in the SERFF Plan Management module no later than May 29, 2023.

Q. What is the Approved Confidentiality Request deadline?
A. OSI is requiring all confidentiality requests to be submitted at least 30 days prior to the targeted QHP application submission date. Approved confidentiality determinations must be included in the QHP Application upon submission.

Q. Can OSI provide additional technical guidance on the steps required to successfully file forms in SERFF on 5/22/2023 and rates on 5/29/2023?
A. Yes. OSI is requesting that carriers submit their form/rate filing by 5/22/2023 and upload their rate materials into the filing by the 5/29/2023 deadline.

Q. What ECP data and analysis is required beyond the ECP-NA template?
A. No analysis is required beyond the ECP-NA template completion.

Q. Regarding required information describing Quality improvement initiatives, is there a requirement to re-submit information from the most recent compliance plan, or will it suffice to cross-reference that plan's SERFF# in the Filing Description?
A. The most recently approved quality improvement plan shall be cross-referenced in SERFF and all documents pursuant to these requirements shall be uploaded in SERFF. See https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/aca-mqi/aca-mqi-landing-page for more information related to Quality Improvement.

Q. Specific to formulary availability, can OSI please clarify where beWellnm publishes the formulary?
A. The formulary is available on the beWellnm website through the SBC link.

Q. Is there a template or specific format carriers should follow in providing "a summary of the changes?"
A. Yes, the template was provided as part of the rate guidance.

Q. Regarding the Standardized Naming Convention that applies to ECPT – Essential Community Provider Template, those files are ordinarily automatically assigned a name during the finalization process. Is OSI instructing carriers to rename the file(s) prior to submission?
A. No.

Q. Regarding the naming convention for SBC's, can OSI clarify whether the filing convention should be: CarrierNameMMDDYY…, or CarrierNameMDYY?
A. The carrier name should be CarrierNameMMDDYY.

Q. Regarding the Plan and Plan Variant Marketing Names, can OSI clarify when issuers should use a "short name," and how to apply the instruction that reads: "[i]f there is a long name, there must be a legend to specify the short and long name."
A. If the carrier is using a long name and a short version of that name, OSI requires carriers to provide a legend that specifies how the long name is shortened and indicates that the long name and short name correspond with the same plan. This is for clarity and consistency purposes.

Q. Regarding the discussion of Turquoise plans within the sub-section titled, Plan and Plan Variant Marketing Names, can OSI define/clarify the term "base plan," and confirm whether Turquoise plan Marketing Names should include reference to the metal level?
A. The base plan, also known as the "standard variant" is the -01 on-exchange Gold or Silver variant that represents a plan's cost sharing design without any cost sharing variations applied. The base plan metal level should not be included in the plan name for the Turquoise variant. For example, for "HMO Healthy Choice 1" plan, the Turquoise plan variant should be HMO Healthy Choice 1 Turquoise 3".

Q. With respect to the requirement that: "[e] ach EOC or COC must describe in detail how the individual and family Deductible and Maximum Out of Pocket Limits apply," does OSI have prescribed language that issuers should include?
A. No.

Q. Specific to the second to the last bullet point under the sub-section titled, Summary of Benefits and Coverage (SBC), can OSI clarify or elaborate on when, and in what document, Issuers should "justify a change in the CSR variant(s) if the old variant(s) still meet the applicable AV threshold(s)."

A. If old variants still meet the applicable AV thresholds, they may still be used provided that they meet the requirements that each variant closely resembles the general features of the standard variant of the underlying plan. See the section titled "Turquoise Plans" for more information. Please note that OSI will release plan designs for Silver CSR variants once the 2024 AV Calculator is finalized.

Q. Can OSI confirm the number of visits that apply to the acupuncture and chiropractic for non-habilitative and non-rehabilitative services?
A. 20.

Q. Can OSI confirm the deadline for URLs?
A. The URL Template links must be live and active by 9/1/2023. URL links in consumer facing forms, including but not limited to EOCs and SBCs, must be active during the QHP review period.

Q. Are Issuers required to submit binders/templates for Small Group plans only offered off-exchange?
A. No. Issuers are not required to submit templates and binders for off-exchange only plans.

Q. Specific to the cost-sharing data to be included in Plans and Benefit Template (PBT) requirements (set forth in SERFF Template Requirements for QHP's), do the instructions provide for the population of the cost sharing (copay/coinsurance) fields with the values for the most common setting? Issuers are concerned that while the PBT will permit the data entry of the higher cost sharing value (leading to the intended beWellnm display desired by the OSI), the deviation from CMS instruction will affect the AV calculation for plans. As the PBT AV calculation utilizes cost sharing values entered for certain benefits, it would generate outputs that are different from the standalone AV calculator (i.e. AV calculator screenshots), and bring the binder filing (i.e. PBT) out of alignment with the components of the rate filing (URRT, AV screenshots, etc.).
A. OSI is following the CMS recommendation of using the cost sharing (copay/coinsurance) that is most commonly used.

Q. With respect to the description of Plan Crosswalk, it appears that there are typographical errors in the direction regarding comparison of PY2023 and PY2024 plans.
Updated.

Q. The URL "live and active" date at the end of the sub-section titled Issuer URL Template should be updated to reflect the 2024 timeline in Section II.
A. Updated.

Q. Regarding the instructions set forth in the sub-section titled: Required Use of CMS Review Tools and Data Integrity Tool, will Issuers be permitted to use and report output from CMS' new MPMS module in HIOS?
A. OSI is asking carriers to submit copies of the CMS review tools outside of the MPMS module. This will ensure that there are no discrepancies between the two tool review systems.

Q. Regarding the requirements of ID Cards, BCBSNM asks that OSI consider the font size and very limited space constraints that apply to ID cards which may not allow for all required verbiage to be included on a single wallet-sized ID card.
A. OSI appreciates the consideration request. However, in order to comply with the regulatory requirements related to information included on the ID cards, and avoid consumer confusion regarding behavioral cost sharing, we ask that the information is included on the card.

Q. Issuers recommend that OSI and beWellnm not further limit the number of non-standardized plans. This may cause consumer abrasion, as consumers may lose access to the current plan they are enrolled in and have to choose from a limited selection of plans.
A. Research suggests that choice overload can make it difficult for consumers to navigate their options. CCIIO provided compelling evidence of this phenomenon in a recent Issue Brief and proposed similar requirements in the 2024 NBPP. Given the significant number of issuers and plan offerings available to consumers during the 2024 Plan Year, OSI will allow issuers to offer no more than 3 plans associated with a statewide network for Silver and Gold plans (1 standardized and 2 non-standardized plans) and 1 plan associated with a limited, non-statewide network (1 non-standardized plan).

Q. Is the 2 non-standardized plan design per network or in total? For example, if an issuer offers Silver 1 & 2 on one network and Silver 3 & 4 on another network, where each pair represents a different benefit design, would the Silver 1 & 2 be the only plans that can be offered as non-standardized plans?
A. Yes.

Q. In terms of the current NM standardized plan design structure, having specialty Rx at a lower member cost-sharing than non-preferred brands, as well as the 2-speciality tier approach, is not typical and increases complexity in the plan design process. Can the Rx tiering structure be aligned with the CMS standardized plan design?
A. Standardized plan designs are prescribed as authorized by the beWellnm Board of Directors. BeWellnm' s Health Benefits Committee accepted several rounds of stakeholder feedback and concluded that the adopted plan designs reflected carefully crafted priorities, as noted in responses to the final round of comments.

Q. If issuers offer mirrored plans of the standardized plan on a narrow network, would that be counted towards the limit of 2 non-standardized plan designs?

A. Each on-exchange plan must be accompanied by an off-exchange mirrored plan. Mirrored plans do not count towards the limit on non-standardized plans.

Q. Will specific plan naming guidance for the standardized plans be released?
A. Specific naming conventions will be released upon beWellnm' s communications plan for Standardized Health Plans.

Q. Will plans designs for the 73/87/94 plan designs of the standardized silver plan be provided?
A. OSI will issue standardized plan designs for federal CSR variants upon the finalization of the 2024 AV Calculator.