

## **Benchmark:**

Question 1: Can you please confirm that stand alone dental plans should be using the dental benefits listed in the Keystone plan and NOT the FEDVIP dental plan? Also, we noted in the Keystone plan that the dental services listed are not categorized into Preventive, Basic, and Major services. Our plans are not currently designed with a copayment assigned to each code, rather, we pay a percent based on the categorized code (IE: we pay 80% for a basic service and 50% for a major service). Can you please provide some guidance on how these portion of our forms will be reviewed? Do we need to list out each code that is covered?

Answer: The plan year 2017 benchmark plan is the Keystone Health Plan East (KHPE) plan, which includes dental benefits. Issuers should use the benefits included in the KHPE plan to determine the pediatric dental benefits considered essential health benefits. All submitted forms will be reviewed against the KHPE benchmark plan.

As stated in 45 CFR §156.115(a), EHBs must be substantially equal to the EHB-benchmark plan. Your company's plan design may be approved provided it is not more restrictive than the benchmark plan. Keep in mind that preventive care services must be provided without cost-sharing. You are not required to list out each code that is covered, but if you do not list pediatric dental services in a manner that is easily compared to the benchmark plan, you should be prepared to submit a crosswalk upon request to demonstrate that the covered benefits are substantially equal.

Question 2: The 2017 Benchmark plan includes an adult routine eye exam benefit. We understand that CMS prohibits inclusion of the benefit as an Essential Health Benefit. If PA issuers are required to include this benefit, the EHB percent of premium will be below 100% for all issuers. Are we still to include this as a part of our benefit packages?

Answer: Issuers are not required to include adult routine eye exam as a benefit. As noted in the question, routine non-pediatric eye exam services are not considered an EHB per federal regulation at 45 CFR §156.115(d).

Question 3: Please confirm the Rehabilitative and Habilitative benefits covered under the new benchmark plan.

Answer: Please refer to the benchmark plan document available at <https://www.cms.gov/ccio/resources/data-resources/ehb.html#Pennsylvania>. Relevant pages include but are not necessarily limited to pages 9, 51-52, 129, and 149

Question 4: The benchmark plan includes two differing definitions of pediatric: "Preventive Care – Pediatric" - the definition is "members under the age of 18" and "Dental (Pediatric)" - the definition is "members under 19 years of age". Please confirm that issuers are to use "up to the age of 18" as the definition of pediatric, which is consistent with the usage of pediatric by the US Preventive Services Task Force and in the PA code § 3490.4.

Answer: As stated in federal regulations at 45 CFR 156.115(a)(6) "Provision of EHB means that a health plan provides benefits that— [...] For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age." Accordingly, issuers are required to cover pediatric EHBs until at least at least the end of the month in which the enrollee turns 19.

Question 5: The 2017 Benchmark plan includes an adult routine eye exam benefit. We understand that CMS prohibits inclusion of the benefit as an Essential Health Benefit. If PA issuers are required to include this benefit, the EHB percent of premium will be below 100% for all issuers. Are we still to include this as a part of our benefit packages?

Answer: Issuers are not required to include adult routine eye exam as a benefit. As noted in the question, routine non-pediatric eye exam services are not considered an EHB per federal regulation at 45 CFR §156.115(d).

### **Binders:**

Question 1: For plan binders, issuers should submit one binder for Individual, one for Small Group, per legal entity? Or can multiple legal entities (HIOS IDs) be submitted in one binder?

Answer: Each entity must submit its own separate binders; multiple legal entities are not permitted in the same binder.

Question 2: In the past, we submitted two modules in HIOS for the QHP submission process. There is a QHP Issuer Module section and the QHP Benefits and Service Area Module. All of the issuer attestations, compliance plan, compliance org chart, NCQA information etc. were submitted in the Issuer Module. Now that we are using SERFF, how will we submit the information that was previously entered via the QHP Issuer Module?

*Answer:* The CMS QHP Issuer Compliance Plan and Organizational Chart Cover Sheet Template and SPM Issuer Attestations: Statement of Detailed Attestation Responses template are available in the Attestations section of the CMS QHP templates page available here: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>. Issuers are expected to complete the required templates and upload them under the Supporting Documentation tab for the binder in SERFF.

### **Checklists:**

Question 1: The slides indicated that the compliance checklist must be completed in its entirety. That being said, some of the questions are only applicable to Small Group or Individual. In those cases, if the question would not apply to that specific market segment, would be check yes and then for location include "Not Applicable"?

*Answer:* Each policy submission must include a completed compliance checklist. Individual forms must be submitted separately from small group forms, so there will be a checklist included in each submission that is applicable to only that specific market segment. The Compliance Checklist contains a column entitled "Product Applicability" which specifies the market segment to which each requirement pertains. If a requirement does not pertain to the filing (e.g., if it is a small group filing and there is a requirement listed that does not include small group in the product applicability section) that section may be left blank.

### **Data Validation**

Question 1: On a recent call with CMS with multiple issuers, there was discussion regarding the importance of an Issuer using the QHP validation tools available in HIOS as part of the actual submission. There was discussion that failure to use the HIOS validation tools, at the point of submission, could result in the potential rejection of an issuer's filing. Given the new approach for Pennsylvania issuers to

submit QHP filings via SERFF, an issuer will not have access to the HIOS validation tools, which seems to put us a risk. Will the PID, in some capacity, use the HIOS validation tools as part of their SERFF transmission to CMS of an issuer's QHP forms and plan binders? We understand issuers should use the DIT for individual template errors prior to submission, but our concern is specifically with cross-validation.

Answer: We strongly advise issuers to use the DIT prior to submission. Cross-validation will occur when PID conducts the file transfer from SERFF to HIOS. If QHP filings fail cross validation in the transfer process, PID will notify the issuer so that the filing can be revised and then PID will try transferring the QHP filings again. PID has moved its submission deadline to allow additional time for the transfer to HIOS to occur, and to address any validation errors that may arise.

Question 2: We understand the post-QHP submission data correction notification process; however can PID elaborate on the actual real-time QHP submission filing error correction process? Or will the errors not be available in real-time, as they previously have been with HIOS submissions?

Answer: Should PID encounter any errors during the SERFF to HIOS transfer (other than actual HIOS system issues), issuers will be promptly notified. It will not be 'real time' but we will strive to make those notifications as quickly as possible to allow sufficient time for revisions.

Question 3: What process will be in place to notify an issuer of real-time submission errors with the QHP filing so that an issuer can review and make corrections during the open submission window?

Answer: Should any submission errors occur, PID will reach out to the contact person on the binder immediately to provide information on the error and allow for revisions to be made. As we have built in additional time for corrections before the data lockdown on 5/11/16, we feel that issuers will have sufficient time to make any necessary adjustments.

Question 4: Obviously we plan on running the DIT tools prior to submission (and for any resubmission that may occur during the review periods). Do you ask that issuers upload the completed DIT tools into the binders, say, as part of the supporting documentation?

Answer: We strongly encourage companies to run the DIT tools and, if they encounters any errors, to upload the completed tools as Supporting Documentation along with justification for the errors. This would save time on the front end by addressing the discrepancy immediately.

Question 5: Our prescription drug formulary is currently deficient in the ophthalmic anti-allergy agents category based on the new Pennsylvania benchmark plan. The benchmark plan includes 10 distinct chemical entities in this category while our formulary includes 9. Based on the Category and Class Summary provided within the PY2017\_EHBCrosswalk, there are only 9 chemically distinct drugs within this category. As there are only 9 chemically distinct drugs in this category it is not possible for us to meet the benchmark plan. How are we to proceed?

Answer: CMS has noted that the number of chemically distinct drugs in this category has decreased to 9 since the benchmark plan existed in 2014, and therefore issuers only have to comply with the 9. Pages 13 and 14 of the "Formulary Review Suite Instructions" state (relevant information shown below):

As noted in the definitions for the columns in this worksheet:

- **Benchmark Reevaluation:** The updated benchmark counts based on the most up-to-date EHB Rx Crosswalk. This column is only for reference purposes since issuers are still required to meet or exceed the values in "Benchmark Count" column.
- **List [#] Met? (Yes/No):** An indication whether the category and class has met the benchmark count. o **Yes:** The drug count meets the state EHB benchmark count. No further review is required.
  - **Yes – Reevaluated:** The drug count meets the reevaluated benchmark count, but it does not meet the state EHB benchmark count. The decision is left to the state to require a further review
  - **No:** The drug count does not meet the state EHB benchmark count. A further review is required.

In several situations it is impossible for a particular category and class to meet the EHB benchmark count. This happens because the number of available chemically distinct drugs in the EHB Rx Crosswalk decreased for certain categories and classes. This is due to timing difference between establishing EHB benchmarks counts and the update of the EHB Rx Crosswalk. In these situations, a further review of the drug list is not required. The following categories and classes affect the states listed in Table 1.

Table 1 Impossible Situations to Meet EHB Benchmark Count

Category Class ID	Category	Class	States Affected
71	Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors (NRTI)	AZ; IN; MA; ME; MI; OH; OPM - 1; OPM - 2; OPM - 3; SC; VA
127	Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Estrogens	AZ; IN; MA; ME; OH; OPM - 1; OPM - 2; OPM - 3; SC; VA
129	Hormonal Agents, Stimulant/ Replacement/ Modifying (Sex Hormones/ Modifiers)	Progestins	AZ; IN; MA; ME; OH; OPM - 1; OPM - 2; OPM - 3; SC; VA
133	Hormonal Agents, Suppressant (Adrenal)	No USP Class	AL; AK; AZ; FL; GA; IN; LA; ME; MA; MI; MN; NY; OH; RI ;SC; VA; WA; WI; WY; OPM - 1; OPM - 2; OPM - 3
144	Metabolic Bone Disease Agents	No USP Class	AZ; SC
147	Ophthalmic Agents	Ophthalmic Anti-allergy Agents	AZ; CT; DE; GA; HI; KY; MA; OPM - 1; OPM - 2; OR; PA; SC; TN; VT; WA; WV
165	Therapeutic Nutrients/ Minerals/ Electrolytes	Electrolyte/Mineral Replacement	AZ; MA; OPM - 1; OPM - 2; SC

### **Exchange Intentions**

Question 1: It was stated that Exchange intentions should be On or Off only—if selling both On and Off Exchange, can issuers state this?

Answer: Exchange intentions should be stated as On Exchange or Off Exchange Only. Products that are sold On Exchange generally must be available Off Exchange as well, so by default, On Exchange means ‘both.’ To avoid confusion, we request that ‘On Exchange’ or ‘Off Exchange Only’ be used.

Question 2: Page 11 of the Plan Year 2017 Form and Binder Webinar slide deck: Please confirm that the Department will accept one form filing submission that includes on and off exchange options of the same sub-TOI product (i.e., Individual PPO).

Answer: As long as the submission includes the same benefit package for the same product type, On Exchange and Off Exchange Only can be submitted as one form filing.

### **Form Requirements**

Question 1: Will you require an Outline of Coverage this year and if so is this for Individual or Small Group and for which products?

Answer: Our position on the Outline of Coverage has not changed. An OOC is required for individual plans; for Small Group plans, a Certificate of Coverage is required.

Question 2: Should the benefit matrix be uploaded in PDF or Excel? Excel was mentioned on the call/slides but unless an enhancement has been made, Excel format could not be uploaded for 2016 submissions in *Supporting Documents*?

Answer: The benefit matrix should be provided in Excel. The SERFF Help Desk has confirmed that the only limitation for uploading excel formatted forms is that the file size cannot exceed 3MB.

Question 3: Will the Attestations document that previously was submitted in HIOS be submitted within SERFF? If yes, should it be uploaded into the *Supporting Documents* tab of the plan binder, or elsewhere?

Answer: Submit the SPM Issuer Attestations Statement of Detailed Attestation responses document on the Supporting Documentation tab of the plan binder under the heading 'Statement of Detailed Attestation Responses for SPM/FFM Issuers.' The SPM Issuer Attestations template is available with the other QHP templates on the CMS website: <https://www.cms.gov/ccio/programs-and-initiatives/health-insurance-marketplaces/ghp.html>.

Question 4: Changes for Small Group Form Filings and 2017 Filing Instructions, Page 1 – Under the Timeline for Form and Binder Filings instruction, it states that “all insurers . . . must file their forms (including all required documents for policies, certificates or membership contracts) and plan binders . . . no later than April 27, 2016”. Given the instruction and other changes, we want to make sure our small group form submission checklist is complete and up to date.

We took a look at one of our 2016 small group form filing as a reference point. Looking at the 2017 Instructions and Worksheet, we are thinking a complete list of what the Department requires for 2017 small group filings can, by comparison, be summarized as follows:

<p><b>2016 Filing Submission Forms Checklist</b>  <b>Form Schedule (FS)</b>          Compliance Checklist and Certification</p>	<p><b>2017 Filing Submission Forms Checklist</b>  <b>Form Schedule (FS)</b>          Contract form (clean)</p>
<p><b>Supporting Documentation (SD)</b>          Transmittal letter</p> <p>Contract form (clean and red-lined version)</p> <p>Statement of Variability (metal levels)</p> <p>Preventive Services Certification</p>	<p><b>Supporting Documentation (SD)</b>          Transmittal letter          Compliance Checklist and Certification          Contract form (red-lined version)</p> <p>Statement of Variability (metal levels)</p> <p><del>Preventive Services Certification</del>          Preventive Services list/chart          Summary of Benefits and Coverage (SBC)          – new for 2017</p>

It is our intent, unless you advise us otherwise, to not include member benefit booklets, group application forms and marketing materials.

Answer: The member benefit booklets and application must be included on the Form Schedule. Marketing material is not required, but the Department retains its right to request such materials if needed.

Question 5: Just to confirm, only a COC is required for Small Group; not a Required Outline of Coverage?

Answer: That is correct; outlines of coverage are not required for small group business but the Certificate of Coverage must be provided on the form schedule for review.

Question 6: Our question is about the inability to use riders to provide certain benefits, such as pediatric dental and pediatric vision. The Department cited a portion of the 2017 Unified Rate Review Instruction, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Unified-Rate-Review-Instructions.pdf>. Our reading of that section indicates that the cited language refers to “optional benefits”. The benefits that we provide through a rider are not optional benefits, but are EHBs. Therefore, our read is that the cited section does not apply. We would like to be able to continue our practice of providing these benefits via a rider. Note that these riders not optional and are always provided as part of the product.

Answer: Our position on riders remains unchanged. If the benefit is an EHB, such as pediatric dental, it must be embedded in the contract filed for approval. It cannot be added via amendment/endorsement/rider, etc. Excepted benefits can be separately filed and sold with separately approved rates.

### **Large Group**

Question 1: For non ACA/PY2018 Large Group forms that we are building today will the above approach also apply? (...“filing is limited to cost sharing; benefits cannot be variable.”)

Answer: As large group forms are not required until PY18, the Department has not finalized its requirements for this specific market type. Issuers will be provided with guidance as it is developed.

Question 2: For non ACA/PY2018 Large Group forms that we are building today will you require a matrix showing all cost share options similar to that being built for ACA Small Group and Individual?

Answer: As stated above, our requirements have not yet been finalized for this specific market type. At this point in time, it would seem a fair assumption that a matrix will be required.

## **Limited Benefit**

Question 1: We had previously reviewed and picked up on the fact that PID Notice 2016-01 indicated that small group limited benefit forms (defined in footnote 5 as including dental and vision) would have to be filed sometime this year. However, since their review was not tied into the SHOP plan certification, we thought forthcoming guidance on Student Health Plans would be accompanied with more information on other Department form reviews to occur this year, including non-SADP dental and vision products.

Answer: SADP benefit forms should be filed at the same time as QHPs are required to be filed. Other excepted benefit forms can be submitted at a later time.

Guidance for student health will be provided on its own, and will not contain guidance with regard to non-SADP dental and vision products.

## **Miscellaneous**

Question 1: I have been informed that some of our online applications may not be available by the 4/27/16 date. Would we be able to file 'place holder forms' that can be replaced with the final versions once they are available? If no, can an amendment be done to the filing once the online applications are final?

Answer: We will allow an amendment to the filing to add the final online applications, but the company should make every effort to include these applications at the time of submission. A late filing of these applications could potentially mean insufficient time for review and approval of the forms, thereby jeopardizing use of these applications.

Question 2: For vision product filings, since there is not a separate 2017 Compliance Checklist for vision products, should issuers complete the Major Medical compliance checklist?

Answer: We suggest using the ACA-Compliance Checklist for Stand Alone Dental. If a requirement does not pertain to vision, mark that requirement as N/A

Question 3: In the past, we submitted two modules in HIOS for the QHP submission process. There is a QHP Issuer Module section and the QHP Benefits and Service Area Module. All of the issuer attestations, compliance plan, compliance org chart, NCQA information etc. were submitted in the Issuer Module. Now that we are using SERFF, how will we submit the information that was previously entered via the QHP Issuer Module?

Answer: The CMS QHP Issuer Compliance Plan and Organizational Chart Cover Sheet Template and SPM Issuer Attestations: Statement of Detailed Attestation Responses template are available in the Attestations section of the CMS QHP templates page available here: <https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html>. Issuers are expected to complete the required templates and upload them under the Supporting Documentation tab for the binder in SERFF.

Question 4: Please confirm that issuers should continue to exclude Elective abortion coverage in accordance with PA Act 2013-13.

Answer: PA Act 2013-13 still applies and issuers should continue to follow this Act.

Question 5: Under our HMO issuer ID, in addition to offering HMO plans, we currently offer several POS plans including a catastrophic POS plan. If we would chose to continue to offer HMO plans but, under POS, only offer the catastrophic POS plan for 2017, would this be sufficient to remain in the POS market?

Answer: The requirement for gold and silver metal level plans is set at the market level, so we are not aware of any requirement that would preclude you from offering only a catastrophic POS plan.

## **Network Issues**

Question 1: In reviewing the QHP Binder filing requirements for the 2017 Plan Year, it was unclear to us whether a formal network filing to the state is required.

Please confirm? If required, please advise where in the guidance this is referenced including requirements and in which filing this would be submitted (forms vs. qhp vs. rates).

Answer: The Department of Health Bureau of Managed Care will be responsible for reviewing the Network Adequacy/ECP and Service Area templates that are submitted within the binder.

If the company is utilizing a network that has been approved and remains unchanged, the information regarding the network must be recorded on the Compliance Checklist.

If the network is new, or there is a change to the service area (or other change), a submission is required to be made for review by the Department of Health by April 27, 2016.

Question 2: We're hoping to get some input from the PID about the network adequacy standards that will be used as part of the QHP certification process. We understand that the Bureau of Managed Care will have a role in reviewing information regarding network adequacy, but we're trying to determine to what extent, if any, the CMS "reasonable access" standard will apply. We'd also like to understand if we must submit any network filings with the Bureau of Managed Care by 4/27/16.

Answer: The Bureau of Managed Care will review the following QHP templates and supplemental justification forms:

- ECP/Network Adequacy template
  - o Essential Community Provider Supplemental Response Form
  - o Network Adequacy Justifications
- Service Area template
  - Partial County Service Area Justification

Insurers are expected to submit these documents through SERFF, along with their other QHP templates. These do not have to be submitted directly to the Bureau of Managed Care; the Bureau of Managed Care will be able to access these documents through SERFF. The Bureau of Managed Care will review these templates for compliance with network adequacy standards established in state law and for compliance with the essential community provider standards established in federal law and guidance.

If the filed templates are not in compliance with state network adequacy standards, the Network Adequacy Justification form should be used to provide an explanation and propose a plan for remedying the non-compliance. If the filed templates do not meet the standards outlined in CMS' Final 2017 Letter to Issuers, an explanation should also be provided using the Network Adequacy Justification form.

Insurers should continue to file any proposed new networks and any proposed service area expansions or changes to existing networks with the Bureau of Managed Care directly using the existing process established by the Bureau of Managed Care. If an issuer proposes to use a new network for an individual or small group plan to be sold as of 1/1/17, or to change an existing network, the insurer should file the new network or network change with the Bureau of Managed

Care by 4/27/16 so that the new network/network change may be reviewed in conjunction with the QHP templates.

### **Optional Benefits**

Question 1: The first bullet under the heading 'For all filings' states "All benefits offered in a plan are embedded in the plan (i.e., no riders)." The referenced CMS document addresses rate filings. Is this also a requirement on how policies are structured? Our current PPO and HMO policies use riders for prescription drug, pediatric dental and pediatric vision coverage. Can we continue this practice?

Answer: Refer to "Optional Benefits" on page 7 of the 2017 Unified Rate Review Instructions here: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Unified-Rate-Review-Instructions.pdf> Based on this guidance, which refers to benefits which are contract/form related, all benefits must be included in the form itself. Therefore, riders to add EHBs are not permitted.

### **QHP Templates**

Question 1: Are we required to file QHP data templates for off-marketplace individual and group health plans?

Answer: Yes, FFM QHP data templates must be completed for all individual and small group health plans, regardless of whether plans are being submitted for QHP Certification.

Question 2: Can you confirm that the Administrative Template should be uploaded into the *Supporting Documents* tab of the plan binder (as opposed to the Form Filings)?

Answer: Upon further discussion, we have decided to rescind this requirement. Issuers are not required to provide the Administration Template for PY17.

## **SBC**

Question 1: The guidance indicates that Summary of Benefits and Coverage (SBC) forms must be filed at the same time as the policy forms. Is the SBC now a required form? If so, can we show benefit cost share ranges like we do in the Schedule of Benefits included in policies? How do we handle proposed template changes for 4/1/17?

Answer: For PY17, we are requiring that the SBC be submitted on the Supporting Documentation tab in SERFF.

Insurers must submit one SBC per issuer for each product type (PPO, POS, EPO and HMO). For products that include plans designed to comply with metal level actuarial value requirements, please submit an SBC for a silver metal level plan.

The company should submit the current template as part of its PY17 filing.

Question 2: Do the SBC's need to be filed with the form filings or can they be submitted separately as they have in the past?

Answer: The SBCs must be submitted as Supporting Documentation at the time of submission of the form filing. SBCs were requested during the review process previously.

Question 3: Does PID want issuers to submit every single SBC document, or only a subset (example: one sample SBC per filing/ one at each metallic/standard plans only)? The benefit matrix will cover the actual cost-shares associated with all plans so uploading hundreds of documents seems like a large amount for issuers to submit (there is a limit to uploading 5 documents at a time) and for PID to review?

Answer: Insurers must submit one SBC per issuer for each product type (PPO, POS, EPO and HMO). For products that include plans designed to comply with metal level actuarial value requirements, please submit an SBC for a silver metal level plan.

Question 4: Due to 4/1/2017 being new date that group plans will need to be on the new SBC template will issuers need to submit SBCs to the PID on the 2012 template for new/renewal groups eff 1/1 – 3/1/2017 and then will we need to file any new/renewing groups with eff dates of 4/1 – 12/1/2017 on the new template?

Answer: The Company should submit the current template as part of its PY17 filing.

Question 5: We would like to clarify that we are required to submit the existing SBC template since the revised template has not been finalized? Also, will it be necessary to submit the revised template prior to 4/1/2017?

Answer: The Company should submit the current template as part of its PY17 filing.

### **Timelines**

Question 1: Page 5 shows the Form & Binder filings being due to the PID by 4/27/16 but the Rate filings are not due until 5/11/16; Page 32 mentions that if the rate filing is not submitted with the Form filing by 4/27, then the Binder filing must be updated by 5/12 to link to the rate filing on the "Associate Schedule Item" tab.

If the rate filings are not due to the PID until 5/11, what are carriers supposed to submit for the rate filing URRTs & Actuarial memorandums documents to be uploaded as part of the Binder filing due by 4/27?

Answer: Issuers are permitted to submit binders without the URRT Parts I, II and III and any state specific rate Supporting Documentation and Associate Schedule items, but they must be added to the binders by no later than 5/12.

**ALL QHP TEMPLATES, INCLUDING THE FEDERAL RATE TEMPLATE, MUST BE SUBMITTED BY APRIL 27TH AS PREVIOUSLY DIRECTED.**

Question 2: New Product Timing issue – We have a new product for which we have firm provider participation commitments to support as an individual market product to be available January 1, 2017. These same providers are interested in supporting the product as a small group offering but have advised that they are unable to make that decision until it further evaluates the benefits of participation in the individual market version of the product.

If that commitment is expected to happen later this year or early next, we estimate that the small group version of the product would not be ready to be put into the market until July, 2017.

We're assuming that the small group product version would still have to be filed now (before the April 24<sup>th</sup> deadline). Submission for review and approval later this year or early next is not an option. Is that correct?

**Answer:** In order to maintain a level playing field in the insurance market, it has been our policy to require that all filings for all issuers be submitted at the same time, during the QHP application window. Based on this policy, the small group filing should be submitted for approval by April 27<sup>th</sup>. If the provider decides not to implement the small group offering, the filing may be withdrawn.

## **Variability**

**Question 1:** Page 13 of the Plan Year 2017 Form and Binder Webinar slide deck: Does the requirement regarding variability within a product filing apply to small group forms in addition to individual? This limitation would result in additional small group benefit booklet form submissions to reflect a variance that may or may not be applicable to a plan design, but would have to be accounted for. For example, without the applicable variability option within the small group benefit forms the exemption for religious employers and accommodations for additional non-profit religious organizations applicable to Women's Preventive Health Care would require twice as many form submissions for review/approval by the Department.

**Answer:** The Department will permit variability in language regarding contraceptive coverage to account for the accommodations provided under federal law for religious employers and certain other organizations. If you choose to use variable language, this language must be marked in the policy form as variable, and the filing information must indicate to which types of entities each variation applies.

**Question 2:** Regarding the statement "Variability within an ACA-compliant product filing is limited to cost sharing; benefits cannot be variable." Does this apply to the Policy/Certificate of Coverage or only the Schedule of Benefits for Small Group?

**Answer:** This requirement applies to the policy, certificate of coverage and Schedule of Benefits for small group.

Question 3: Our previously approved PPO and HMO subscriber agreements use bracketed variables for on and off market enrollment and payment information. Can we continue this practice or do we need to submit separate on and off marketplace forms? Also, we use brackets for contact information such as address, telephone and website. Please confirm that we can continue this practice.

Answer: Variability in enrollment/payment information, contact information, etc. ( 'non-benefit' items) can be used, but must be included in the Statement of Variability and properly designated as variable in the forms.

Question 4: Slide 13, Variability within a product filing is limited to cost-sharing; benefits cannot be variable. Does this apply to the adult dental portion of SADPs or is variability allowed for the adult dental benefits?

Answer: The variability limits are the same for medical and dental filings. Variability is not permitted for benefits in a SADP filing.