Common Issuer Corrections Guidance

Corrections are released in the Plan Management (PM) Community on a rolling basis as CMS completes each review round. Below are examples of the most common corrections identified in issuers' applications, and tips for how to resolve them. CMS recommends issuers use this guide as they prepare their Qualified Health Plan (QHP) Applications.

Click any of the common correction codes below to be taken to a description of the correction and tips on resolving it.

List of Common Corrections

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- Correction Code 130000841

ADMINISTRATIVE

Correction Code 020000231: The IFP Customer Service Toll Free number is not provided for the Issuer Marketplace Information in HIOS Plan Finder. Resubmit to include the missing information.

Administrative information displayed on HealthCare.gov is pulled from the Health Insurance Oversight System (HIOS) Plan Finder Module.

Instructions on how to enter the information are in Sections 3.1 and 3.2 of the HIOS Plan Finder - Issuer User Manual.

Correction Code 020000211: The IFP Customer Service Phone number is not provided for the Issuer Marketplace Information in HIOS Plan Finder. Resubmit to include the missing information.

Administrative information displayed on HealthCare.gov is pulled from the Health Insurance Oversight System (HIOS) Plan Finder Module.

Instructions on how to enter the information are in Sections 3.1 and 3.2 of the HIOS Plan Finder - Issuer User Manual.

CSR – PLAN VARIATION

Correction Code 120000521: The cost-sharing value for the {*copay/coinsurance*} increases as the actuarial values (AVs) increase for the {*AV level*} silver plan variations for the following benefits: {*benefit list*}. Ensure the cost sharing does not increase as the AVs increase.

Successive cost sharing must be followed for each individual benefit. Issuers must use the same cost sharing structure across all plan variations. Issuers also must ensure that each benefit's cost sharing remains the same or decreases (becomes more generous) as the AV of the plan variation increases.

Correction Code 120000161: The silver plan variation submitted has {*Individual/Family-Per-person/Family-per-group*} maximum out-of-pocket (MOOP) value that exceeds the permissible threshold in the {*AV level*} plan variation. Reduce the MOOP value so that it is not greater than the reduced maximum annual limitations on cost sharing.

Issuers must reduce MOOP values for silver plan variations to be equal to or less than the allowable MOOP limits for individuals and families.

Correction Code 120000191: The zero cost-sharing plan variation has non-zero cost sharing for the {*copay/coinsurance*} for the following essential health benefits (EHBs): {*benefit list*}. Resubmit the zero cost-sharing plan variation to have zero or no charge cost sharing for EHBs.

Issuers must ensure that if a benefit is covered, it must be covered at zero costing sharing ($0 or 0%).

Correction Code 120000151: The {*Individual/Family-Per-person/Family-per-group*} maximum out-of-pocket (MOOP) increases as the actuarial values (AVs) increase for the {*AV level*} silver plan variations. Ensure that the MOOP does not increase as the AVs increase. If the MOOP increase as AVs increase, revise the MOOP for the lower AV to be less than or equal to the higher AV.

Issuers must ensure that each MOOP remains the same or decreases as the AV of the plan variation increases.

Correction Code 120000051: The {*Individual/Family-Per-person/Family-per-group*} deductible increases as the actuarial values (AVs) increase for the {*AV level*} silver plan variations. Ensure the deductible does not increase as the AVs increase. If the deductibles increase as AVs increase, revise the deductible for the lower AV to be less than or equal to the higher AV.

Issuers must ensure that each deductible remains the same or decreases as the AV of the plan variation increases.

Data Integrity

Correction Code 990000951: DIT ERROR: Plan ID {*plan ID*} has a Calibrated Plan Adjusted Index Rate of {*Calibrated Plan Adjusted Index Rate value*} and a Rating Factor of {*Rating Factor value (Rating Area number)*} in the Unified Rate Review Template (URRT), and a non-tobacco rate (Age 21) of {*Individual Rate (Age 21) for effective dates*} in the Rates Table Template, for the Rating Area associated with the URRT Rating factor.

The product of the Calibrated Plan Adjusted Index Rate and Rating Factor is {*Product of the Calibrated Plan Adjusted Index Rate and Rating factor*} and cannot vary by more than $2.00 from the corresponding non-tobacco rate (Age 21).

For QHPs, issuers must ensure that the product of the Calibrated Plan Adjusted Index Rate and Rating Factor of the URRT equals the Age 21 non-tobacco rate in the Rates Table Template, for all corresponding rating areas and rate effective dates. This correction is not applicable to stand-alone dental plans (SADPs).

Essential Community Provider

Correction Code 070000151: One or more plan networks do not contain ECPs and an insufficient justification is provided. Submit a revised justification and continue to recruit providers.

Issuers that do not meet the ECP threshold should submit a sufficient justification and continue efforts to recruit providers.

Correction Code 070000631: One or more plan networks do not meet the 20 percent ECP threshold, and an insufficient justification is provided. Submit a revised justification and continue to recruit providers.

Issuers that do not meet the ECP threshold should submit a sufficient justification and continue efforts to recruit providers.

Correction Code 070000641: One or more plan networks do not meet the 20 percent ECP threshold, and no justification is provided. Submit a justification and continue to recruit providers.

Issuers that do not meet the ECP threshold should submit a sufficient justification and continue efforts to recruit providers.

Essential Community Provider (Dental)

Correction Code 070000691: One or more dental networks do not meet the 20 percent ECP threshold, and insufficient justification is provided. Submit a revised justification and continue to recruit providers.

Issuers that do not meet the ECP threshold should submit a sufficient justification and continue efforts to recruit providers.

Stand-Alone Dental Plans – EHB Benchmark

Correction Code 090000321: For Plan ID {*plan ID*}, the {*benefit*} benefit lists a condition limitation on service. Rephrase the free-text language to remove the condition limitation and resubmit the benefits package.

Issuers should remove or modify condition limitation on the respective service.

Correction Code 090000331: For Plan ID {*plan ID*}, the {*benefit*} benefit lists an age limitation on service or does not provide services up to the end of the month in which the individual turns 19. Rephrase the free-text language to remove or modify the age limitation and resubmit the benefits package.

Issuers should remove or modify age limitation on the respective service.

Stand-Alone Dental Plans – EHB Supporting Documents

Correction Code 090000362: For Plan ID {*plan ID*}, the justification Stand-Alone Dental Plan—Description of EHB Allocation was not submitted. Submit this justification.

Issuers should submit sufficient supporting documentation for their description of EHB allocation.

Correction Code 090000392: For Plan ID {*plan ID*}, the justification Stand-Alone Dental Plan—Description of EHB Allocation includes insufficient detail. Resubmit this form describing the methods and specific bases for performing the allocation, and demonstrating that the allocation meets the standards in 45 *Code of Federal Regulations* 156.470(d).

Issuers should resubmit supporting documentation containing sufficient detail for their description of EHB allocation.

Stand-Alone Dental Plans – AV Supporting Document

Correction Code 110000142: For Plan ID {*plan ID*}, the justification "Stand-Alone Dental Plan—Actuarial Value" was not submitted. Provide actuarial supporting documentation for Plan ID {*plan ID*} that certifies the actuarial value (AV) was calculated by a member of the American Academy of Actuaries and performed in accordance with generally accepted actuarial principles and methods.

Issuers should submit required AV supporting documentation.

Non-Discrimination (Clinical Appropriateness)

Correction Code 130000911: The drug list associated with this plan includes {*Number of drugs in specified condition's drug class that are included in drug list*} {*covered / unrestricted*} drug(s) in the {*Name of medical condition; name of specified drug class*} drug class. The minimum threshold for {*covered / unrestricted*} drugs in this drug class is {*Minimum number of covered drugs required in drug class to pass threshold*}, so the submitted drug list does not cover a sufficient number of drugs for this class. Refer to the Clinical Details tab in the Formulary Review Suite to determine which chemically distinct drugs in the deficient condition and class can be covered to meet the minimum coverage thresholds. The Formulary Review Suite can be accessed at https://www.qhpcertification.cms.gov/s/Review%20Tools.

Modify the drug list associated with this plan to meet or exceed this requirement or submit a Combined Prescription Drug Supporting Documentation and Justification. If a justification has already been submitted, it is reviewed and identified as insufficient.

Issuers should use the Formulary Review Suite to determine drugs that can be covered in deficient classes to pass the review.

Issuers should submit a justification response if plans do not meet or exceed this requirement. Justification responses should describe why the prescription drug benefit design is non-discriminatory, offering any clinical support or evidence for the design.

NON-DISCRIMINATION (FORMULARY OUTLIER)

Correction Code 130000841: The plan has {*plan unrestricted drug count*} chemically distinct drugs without prior authorization or step therapy in the {*USP category; class*}. An issuer must have an unrestricted count equal to, or greater than, the applied lower outlier threshold values to be considered compliant. The minimum number of chemically distinct drugs that must be offered without prior authorization or step therapy in the {*USP category; class*} is {*Applied threshold*}. Refer to the Formulary Outlier Details tab in the Formulary Review Suite to determine which chemically distinct drugs can be covered without restriction in the deficient categories and classes. The Formulary Review Suite can be accessed at https://www.qhpcertification.cms.gov/s/Review%20Tools.

Modify the drug list associated with this plan to meet or exceed this requirement or submit a Combined Prescription Drug Supporting Documentation.

Issuers should use the Formulary Review Suite to determine drugs that can be covered in deficient classes to pass the review.

Issuers should also offer drugs in the deficient classes without restriction or submit a justification response. Justification responses should describe why the prescription drug benefit design is non-discriminatory, offering any clinical support or evidence for the design.