

Common Issuer Corrections Guidance

Required Qualified Health Plan (QHP) Application corrections are released in the Plan Management (PM) Community on a rolling basis as the Centers for Medicare & Medicaid Services (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 QHP Applications.

CMS also recommends issuers download the QHP Certification Issuer Toolkit from the [Application Submission webpage](#) and review the "Data Changes and Corrections" section for additional guidance on addressing CMS-identified corrections.

Click any of the common correction codes below to be taken to a description of the correction and tips on resolving it, or click a review area to be taken to all associated common correction codes.

List of Common Corrections

Review Areas	Common Correction Codes
Accreditation	Correction Code 010000161
Administrative	Correction Code 020000231
	Correction Code 120000051
Cost Sharing Reduction (CSR) - Plan Variation	Correction Code 120000161
	Correction Code 120000191
	Correction Code 120000521
Data Integrity	Correction Code 990000661
	Correction Code 990000951
Essential Community Provider (Dental)	Correction Code 070000691
	Correction Code 070000151
Essential Community Provider (Medical)	Correction Code 070000631
	Correction Code 070000641
Non-Discrimination (Clinical Appropriateness)	Correction Code 130000911
Non-Discrimination (Formulary Outlier)	Correction Code 130000841
Stand-Alone Dental Plans – Essential Health Benefits (EHB) Benchmark	Correction Code 090000321
	Correction Code 090000331
Stand-Alone Dental Plans – Actuarial Value (AV) Supporting Document	Correction Code 110000142
Stand-Alone Dental Plans – EHB Supporting Documents	Correction Code 090000362
	Correction Code 090000392
Transparency in Coverage	Correction Code 250000012
	Correction Code 250000112
	Correction Code 260000051
	Correction Code 260000171
URLs	Correction Code 260000311
	Correction Code 260000351
	Correction Code 260000371

Last updated April 2, 2021. Check the [QHP Application Corrections webpage](#) of the QHP certification website to confirm whether a more recent version of this document has been posted.



Accreditation

Correction Code 010000161: All issuers entering their second (or later) year of certification must be accredited by one of the HHS-recognized accrediting entities. Submit documentation from the accreditation entity specifying when the survey is scheduled.



Issuers should submit documentation from their accrediting entity that details the timeline for achieving accreditation.

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 the www.HealthCare.gov website is pulled from the Health Insurance Oversight System (HIOS) Plan Finder Module. Instructions on how to enter the information are in Section 3.2 of the HIOS Plan Finder - Issuer User Manual.

CSR – Plan Variation

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. Please ensure the deductible does not increase as the AVs increase.



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

Correction Code 120000161: The silver plan variation submitted has a *{Individual/Family-Per-Person/Family-Per-Group}* maximum out-of-pocket (MOOP) value that exceeds the permissible threshold in the *{AV Level}* plan variation. Please ensure the MOOP is no greater than the reduced maximum annual limitations on cost sharing.



Issuers must reduce Maximum Out of Pocket (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 covered, the benefit is covered at zero costing sharing (\$0 or 0%).



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. Additionally, issuers also must ensure that each benefit's cost sharing remains the same or decreases (i.e., becomes more generous) as the actuarial value (AV) of the plan variation increases.

Data Integrity

Correction Code 990000661: DIT ERROR: The following plans have a value of 100% in the EHB Percent of Premium field of the Plans & Benefits Template and cover *{Benefit}*: *{Plan IDs}*.

The EHB Percent of Premium field should be less than 100% to account for the plans' coverage of non-EHBs. Please note, pursuant to *45 CFR 156.115*, the following benefits are excluded from EHB, even though an EHB-benchmark plan may cover them: Routine Non-Pediatric Dental Services, Routine Non-Pediatric Eye Exam Services, Long-Term/Custodial Nursing Home Care Benefits, Non-Medically Necessary Orthodontia.



To avoid this error, please ensure that the EHB Percent of Premium field in the Plans & Benefits Template is less than 100% if the issuer intends to cover non-EHBs.

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 in 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 (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 should submit a revised justification and continue to recruit providers.



Essential Community Provider (Medical)

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.

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 was reviewed and identified as insufficient.



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

Submit a justification response. The justification response 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.

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



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

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 – AV Supporting Documents

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.



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.

Transparency in Coverage

Correction Code 250000012: The URL for Claims Payment Policies & Other Information is not active. Submit and maintain an active URL using the Supplemental Submission Module.



Issuers should ensure the Transparency in Coverage URL is live upon initial submission; this submission date does not align with all other QHP URL requirements.

Correction Code 250000112: The URL for Claims Payment Policies & Other Information does not provide links to download applicable claim forms. Update the URL so that it contains links to download all necessary claim forms. Reference the QHP Instructions for example language.



Issuers should ensure the hyperlinks to claim forms are imbedded in the text of the webpage and do not require consumers to log in to access the forms (i.e., the claim forms are publicly available).

URLs

Correction Code 260000051: URL ERROR: The Formulary URL, *{URL}*, associated to Formulary ID *{Formulary ID}* does not contain a *{Plan Year}* Drug Formulary.

All Formulary URLs submitted in the HIOS Supplemental Submission Module must be for the current plan year.



Ensure that the Formulary URL includes the correct application plan year.



Correction Code 260000171: URL ERROR: The Plan Brochure URL, {URL}, associated to {Plan ID} is not active.

All Plan Brochure URLs submitted in the HIOS Supplemental Submission Module must lead to a live, active webpage.



Ensure the Plan Brochure URL is live and active by the deadline communicated in the QHP Data Submission Timeline Bulletin.

Correction Code 260000311: URL ERROR: The Summary of Benefits & Coverage URL, {URL}, associated to {Plan ID} is not active.

All Summary of Benefits & Coverage URLs submitted in the HIOS Supplemental Submission Module must lead to a live, active webpage.



Ensure the Summary of Benefits & Coverage (SBC) URL is live and active by the deadline communicated in the QHP Data Submission Timeline Bulletin.

Correction Code 260000351: URL ERROR: The SBC URL, {URL}, associated to Plan Variant ID {Plan Variant ID} is not unique to its Plan Variation.

URLs submitted in the HIOS Supplemental Submission Module must be unique to a Plan Variant ID. An issuer justification can be provided for a non-unique SBC URL that shares a Network and Service Area ID with another SBC URL.



SBC URLs should be unique to each plan variant. Issuers can re-use the same or similar SBCs, but there should be a unique link for each plan variant.

Correction Code 260000371: URL ERROR: The SBC URL, {URL}, associated to Plan Variant ID {Plan Variant ID} has a {Benefit} cost of {Cost-Sharing Value 1} and a Plans & Benefits Template {Benefit} cost of {Cost-Sharing Value 2}.

{Benefit} cost sharing values must match between the Plans & Benefits Template and the SBC URL.



All values, including cost sharing values, should match between the SBC and Plans & Benefits Template. Please ensure these values match to avoid deficiencies.

