QHP URL Validations and Reviews Checklist

As part of its effort to ensure consumers reviewing plans on the Exchanges can access complete information about plan benefit design when shopping for coverage, the Centers for Medicare & Medicaid Services (CMS) performs checks on URLs submitted within an issuer's Qualified Health Plan (QHP) Application to ensure that (1) they are live and functional prior to QHP Agreement signing and through the end of the plan year and (2) they contain accurate data and adhere to CMS guidelines.

CMS encourages issuers to also check their URLs for functionality and accuracy. The information below may be used by issuers to help identify the kinds of checks CMS performs for each URL and highlights key expectations for URLs provided in the issuer's QHP Application.

All URLs

- All URLs should be submitted by the final deadline for submission of QHP data. URLs should be active and route consumers directly to the relevant information for their standard plan or plan variant by the time the issuer has signed its QHP Agreement.
- URLs must start with "http://" or "https://" and must not contain blank spaces or commas within the URL so that they will work properly for consumers.
- To provide consumers with access to all relevant plan information needed to compare and select plans, issuers should ensure these URLs link directly to up-to-date and accurate information that is readily obtainable on their websites. Issuers should ensure that consumers can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

Summary of Benefits and Coverage (SBC)

Regulations related to the SBC URLs can be found at 45 *Code of Federal Regulations* (CFR) 156.420(h), 45 CFR 155.205(b)(1)(ii), and 45 CFR 147.200. Guidance on how the SBCs are to be completed and SBC templates are available at the CCIIO Other Resources webpage. Additional guidance may also be found in the Instructions for the Plans and Benefits Application Section.

- Benefits coverage and cost-sharing information in the SBC should align with the information included in the issuer's Plans & Benefits Template. Issuers should check SBC headers, general plan information, and both in-network and out-of-network cost-sharing to ensure these are consistent with the information provided in the template.
- SBCs for limited cost-sharing plans for American Indians and Alaskan Natives (−03 plan variants) should indicate consumers pay no out-of-pocket costs for care from Indian healthcare providers (or providers the consumer was referred to by an Indian healthcare provider). Issuers should verify SBCs for these plan variants indicate such coverage is available.

Plan Brochures

Regulations related to the Plan Brochure URL can be found at 45 CFR 155.205 and guidance can be found in the Instructions for the Plans and Benefits Application Section.

- Benefits coverage and cost-sharing information in the Plan Brochure should align with the information input in the Plans & Benefits Template. Issuers should check general plan information and both in-network and out-of-network cost-sharing to ensure these are consistent with the information provided in the template.
- Plan brochures should clearly communicate any cost sharing and other information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage. For example, if the plan has different cost sharing for benefits depending on service location, further details on these cost-sharing differences should be communicated through the plan brochure. Issuers should review their plan brochures to ensure such details are clearly communicated for all benefits to which they apply.

Provider Directory

Regulations related to the Provider Directory can be found at 45 CFR 156.230(b) and additional guidance is available in the Instructions for the Network Identification Application Section.

- Entries in the Provider Directory should include all information required by 45 CFR 156.230(b), including contact information, specialty, if the provider is accepting new patients, and if the provider is in-network. Issuers should review their Provider Directories to make sure these fields display and that there is a process in place to update them regularly.
- If an issuer maintains multiple provider networks, it should be easy to discern which providers participate in which plans and which provider networks; network name does not display on HealthCare.gov, so consumers should not be required to know in which network they are located. Issuers should verify that a consumer can discern if a provider is in or out of network for a particular plan without any information beyond the URL and the fields that display on HealthCare.gov.
- Provider Directories should be easy to access from both the Provider Directory URL and the issuer's home page without creating or accessing an account or entering a policy number. Issuers should ensure they can find the Provider Directory readily from both the URL and from their home page.

Formulary

Regulations related to the Formulary can be found at 45 CFR 147.200(a)(2)(i)(L) and additional guidance is available in the Instructions for the Prescription Drugs Application Section.

- Formulary URLs should direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, specific to a given QHP. Issuers should verify these fields are readily visible on their online formulary.
- Formulary URLs link directly to the formulary, so that consumers are not required to log on, enter a policy number, or otherwise navigate the issuer's website before locating it. Issuers should ensure none of this information is required in order to view the online formulary.
- If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHPs. Issuers should check that a consumer could reasonably identify if a drug is covered for a particular plan without any information beyond the URL and the fields that display on HealthCare.gov.
- Issuers should have two active formulary URLs by the agreement signing deadline, one for the current plan year and one for the upcoming plan year, clearly marking which formulary belongs to which plan year. For example, by the PY20 agreement signing deadline on 9/24/19, issuers should have had an active PY19 formulary for the current plan year that was marked as a PY19 Formulary and an active PY20 formulary for the upcoming plan year that was marked as a PY20 Formulary.

Enrollment Payment

Guidance on Enrollment Payment URLs is available in the Instructions for the Plans and Benefits Application Section.

- Enrollment Payment URLs should link directly to a working payment site capable of collecting a consumer's first-month premium and it complies with the latest payment redirect business service description (optional for stand-alone dental plans). Issuers should confirm the URL is active, check the latest payment redirect business service description to make sure all current requirements are met, and verify that the site can collect premiums.

Transparency in Coverage

Regulations related to Transparency in Coverage can be found at 45 CFR 155.1040(a) and 156.220 and additional guidance is available in the Instructions for the Transparency in Coverage Application Section.

- Each issuer must submit a Transparency in Coverage URL that is live upon submission and is accessible from the plan's public website without requiring an individual to create or access an account or policy number.

- Transparency in Coverage URLs must not go to a single landing page from which all Transparency in Coverage information is accessible.
- Transparency in Coverage URLs must provide information regarding whether an enrollee may have financial liability for out-of-network services, as well as information regarding exceptions to out-of-network liability, such as for emergency services.
- Transparency in Coverage URLs must provide an explanation of whether and under what circumstances an enrollee may be balance billed.
- Transparency in Coverage URLs must provide an explanation of how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim, as well as whether or not claims can only be submitted by a provider, the time limit to submit a claim, a link to download applicable claims forms, and information on where to send them.
- Transparency in Coverage URLs must provide an explanation of what a grace period is, what claims pending is, and that the issuer will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.
- Transparency in Coverage URLs must provide an explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, as well as ways to prevent retroactive denials when possible.
- Transparency in Coverage URLs must provide instructions on how to obtain a refund of premium overpayment.
- Transparency in Coverage URLs must provide an explanation that some services may require prior authorization and/or be subject to review for medical necessity, what the ramifications are if proper prior authorization procedures are not followed, and what the time frame is for a decision based on a prior authorization request.
- Transparency in Coverage URLs must provide an explanation of the internal and external exception processes for enrollees to obtain non-formulary drugs for QHPs, how to complete a drug exception application, and a time frame for a decision by the issuer based on a drug exception request.
- Transparency in Coverage URLs must provide an explanation of what an Explanation of Benefits (EOBs) is, when an issuer sends EOBs to enrollees, how a consumer should read and understand the EOB, and what a Coordination of Benefits is.