2023 QHP URL Validations and Content 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, > (greater than), < (less than), -- (two consecutive hyphens), ' (single quote), 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) Review

Regulations related to the SBC 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.

The SBC review compares the SBC's in-network (Tier 1 & Tier 2) and out-of-network cost sharing data to the cost sharing data in an issuer's Plans & Benefits Template (PBT) to ensure data consistency. Benefits coverage and cost-sharing information in the SBC should align with the information included in the issuer's PBT. 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.

The SBC review allows CMS to uncover inaccuracies in an issuer's SBC Form as well as unintentional data errors in an issuer's PBT. The table below shows the benefits in the PBT and the corresponding benefits in the SBC template. Issuers should review this table to ensure that the benefits are referenced according to CMS guidelines.

Table A. SBC Form to Template Benefits Crosswalk

Common medical event	SBC Form benefit name	Plans & Benefits Template benefit name
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visit to Treat an Injury or Illness
	Specialist visit	Specialist Visit
	Preventive care/screening/immunization	Preventive Care/Screening/Immunization
If you have a test	Diagnostic test (x-ray, blood work)	X-rays and Diagnostic Imaging
	Imaging (CT/PET scans, MRIs)	Imaging (CT/PET Scans, MRIs)
If you need drugs to treat your illness or condition	Generic drugs	Generic Drugs
	Preferred brand drugs	Preferred Brand Drugs
	Non-preferred brand drugs	Non-preferred Brand Drugs
	Specialty drugs	Specialty Drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
	Physician/surgeon fees	Outpatient Surgery Physician/Surgical Services
If you need immediate medical attention	Emergency room care	Emergency Room Services
	Emergency medical transportation	Emergency Transportation/Ambulance
	Urgent care	Urgent Care Centers or Facilities
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient Hospital Services (e.g., Hospital Stay)
	Physician/surgeon fees	Inpatient Physician and Surgical Services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral Health Outpatient Services
	Inpatient services	Mental/Behavioral Health Inpatient Services
If you are pregnant	Office visits	Prenatal and Postnatal Care
	Childbirth/delivery **professional** services	Delivery and All Inpatient Services for Maternity Care Benefits Explanation field
	Childbirth/delivery **facility** services	Delivery and All Inpatient Services for Maternity Care - *facility services only
If you need help recovering or have other special health needs	Home health care	Home Health Care Services
	Rehabilitation services	Outpatient Rehabilitation Services
	Habilitation services	Habilitation Services
	Skilled nursing care	Skilled Nursing Facility
	Durable medical equipment	Durable Medical Equipment
	Hospice services	Hospice Services
If your child needs dental or eye care	Children's eye exam	Routine Eye Exam for Children
	Children's glasses	Eye Glasses for Children
	Children's dental check-up	Dental Check-Up for Children

Please note the "If you are pregnant - Office visits" benefit from the SBC Form must correlate to the "Prenatal and Postnatal Care" benefit found in the PBT. The "Childbirth/delivery **professional** services" benefit cost sharing from the SBC Form must be entered into the PBT Benefits Explanation section for the "Delivery and All Inpatient Services for Maternity Care" benefit. The "Childbirth/delivery **facility** services" benefit cost sharing from the SBC template must correlate to the "Delivery and All Inpatient Services for Maternity Care" benefit found in the PBT.

SBC Review Guidance

- **SBC URLs Are Direct:**
  - If the QHP SBC URL does not lead directly to the SBC Form, the SBC shall be flagged for required corrections
    - Consumers should be able to access the SBC directly with one click from HealthCare.gov

- **SBC Form Layout Matches Template:**
  - An SBC Form with the following conditions shall be flagged for required corrections:
    - Merged Individual Benefits
    - Merged Cost Sharing data
    - Merge data across fields
    - SBC Form is submitted in portrait orientation (cannot read from top to bottom)
    - If a plan covers multiple tiers, ensure Tier 2 information is present
    - A watermark placed over cost sharing information
    - Modified Benefit Names, reference Table A. *SBC Form to Template Benefits Crosswalk* above for the approved benefit names
      - Example: Generic Drugs being referred to as Tier 1/Typically Generic, Low Cost, Preventative
  - As noted in the Instructions for Completing the SBC, please note the following instructions for the "What you will pay" columns:
    - Issuers may vary the number of columns depending upon the type of coverage and the number of preferred provider networks. Most policies that use a network should use two columns, although some policies with more than one level of in-network provider may use three columns. Non-networked plans may use one column.
    - Issuers should denote in these columns exceptions, such as when a specific service is subject to a separate deductible or is covered at no cost.
    - Issuers should insert the terminology used in the policy or plan document to title the columns. For example, the columns may be called "Network Provider" and "Out-of-Network Provider", or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. The sub-headings should be deleted for non-networked plans with only one column.
    - The columns should appear from left to right, from most generous cost sharing to least generous cost sharing. For example, if a 3-column format is used, the columns might be labeled (from left to right) "Network Preferred Provider", "Network Provider", and then "Out-of-Network Provider".
  - Please refer to the CCIIO's "Other Resources" Website for examples of completed SBC templates, which includes sample SBCs for standard plans, -02 plan variants, and -03 plan variants.

- **Provide Clear Dollar Values for Eye Glasses for Children:**
  - If an issuer uses a reimbursement or allowance amount for Eye Glasses for Children instead of a copay or coinsurance, the allowed dollar amounts should be noted in the SBC Form.
    - Acceptable: **"$70 Allowance available for glasses/lenses"**
    - Unacceptable: **"Allowances available for glasses/lenses"**

- **Ensure that the Plans & Benefits Template is consistent with the "Are there other deductibles for specific services?" field on the SBC Form:**
  - A Drug deductible in the Plans & Benefits Template must be displayed on the SBC Form.
- **Clearly and Consistently Label when Deductible Applies:**
  - Whether or not a benefit is subject to deductible must be consistent between the PBT and the SBC Form.
    - If a benefit is listed as "after deductible" on the SBC Form, then it must be listed as "after deductible" on the PBT
    - If a benefit is listed as "after deductible" in the PBT, then it must either be listed as "after deductible" or imply "after deductible" using the disclaimer graphic on the SBC Form
    - If the SBC Form uses the disclaimer graphic to imply "after deductible" for one or more benefits, then no benefits on the SBC Form must say "after deductible" and benefits before the deductible must be clearly identified so the use of the disclaimer graphic is consistent across all benefits
  - ⚠ All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.
  - Example #1 – Acceptable when disclaimer graphic is present
    - SBC: **40% coinsurance**
    - PBT: **40.00% Coinsurance after deductible**
  - Example #2 – Acceptable with disclaimer graphic
    - SBC: **40% coinsurance before deductible**
    - PBT: **40% Coinsurance before deductible**
  - Example #3 – Acceptable with disclaimer graphic
    - SBC: **40% coinsurance after deductible**
    - PBT: **40.00% Coinsurance after deductible**
  - Example #4 – Unacceptable
    - SBC: **40% coinsurance after deductible**
    - PBT: **40.00% Coinsurance**
  - Example #5 – Unacceptable
    - SBC: **40% coinsurance (deductible does not apply)**
    - PBT: **40.00% Coinsurance after deductible**
- **Include Consistent Plan Type:**
  - The SBC Form must contain the same Plan Type field value as the PBT, and issuers should include any additional plan type information like "HDHP" along with but not instead of the plan type
    - Example: If the PBT value is "HMO", then the SBC Form may not say "HDHP" but may use "HDHP HMO" instead
- **Use Consistent Copay Application ("Per Stay", "Per Day") –**
  - How a copy is applied, for example "per Stay" or "Per Day", must be consistent between the PBT and the SBC Form.

- "Per Admission" may be used instead of "Per stay", but not instead of "per day." Any additional details, for example that the per day cost-sharing only applies for a specified number of days, may be added to the Explanations field on the SBC Form.
  - Example #1 – Acceptable Copay Application
    - PBT: $70 per stay
    - SBC: $70 per admission
  - Example #2 – Unacceptable Copay Application
    - PBT: $70 per day
    - SBC: $70 per admission
- **Ensure Out-of-Network Emergency Benefits are not more restrictive than In-Network levels**
  - To meet requirements of the Affordable Care Act, if a group health plan or health insurance coverage provides any benefits for emergency services in an emergency department of a hospital, the plan or issuer must cover emergency services without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network.
  - Issuers should check both their SBC Form and Plans & Benefits Template to ensure cost-sharing is correctly and consistently listed in both places.

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.

- Issuers should ensure consumers are directed to the correct language version of their plan brochure document (e.g., English vs. Spanish).

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 plan year (PY) 2022 agreement signing deadline on September 22, 2021, issuers should have had an active PY2021 formulary for the current plan year that was marked as a PY2021 Formulary and an active PY2022 formulary for the upcoming plan year that was marked as a PY2022 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 that 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 and compliant 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 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.