2024 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) checks URLs in 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. Use the following information to identify the kinds of checks CMS performs for each URL and understand key expectations for URLs in the issuer's QHP Application. The PY2024 URL submission and functional (active) deadline is September 20, 2023.

Summary of Benefits and Coverage (SBC) Review

45 *Code of Federal Regulations* (CFR) 156.420(h), 45 CFR 155.205(b)(1)(ii), and 45 CFR 147.200 contain regulations related to the SBC. The CCIIO Other Resources webpage offers guidance on how to complete the SBCs as well as SBC templates. Refer to the Instructions for the Plans and Benefits Application Section for additional guidance.

The SBC review compares the SBC's in-network (Tier 1 and Tier 2) and out-of-network cost sharing data to the cost sharing data in an issuer's Plans & Benefits Template (PBT) for data consistency. Align benefits coverage and cost-sharing information in the SBC with the information in the issuer's PBT. Check SBC headers, general plan information, and in-network and out-of-network cost-sharing for consistency with the information in the template. SBCs for limited cost-sharing plans for American Indians and Alaskan Natives (−03 plan variants) must indicate that 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). Verify that SBCs for these plan variants indicate the availability of such coverage.

The SBC review enables CMS to uncover inaccuracies in an issuer's SBC Form as well as unintentional data errors in an issuer's PBT. Table A shows the benefits in the PBT and the corresponding benefits in the SBC template. Review this table to ensure that 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

Table A. SBC Form to Template Benefits Crosswalk

Common medical event	SBC Form benefit name	Plans & Benefits Template benefit name
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	N/A
	Childbirth/delivery **facility** services	Delivery and All Inpatient Services for Maternity Care
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 (Private Duty Nursing—KS issuers only)
	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

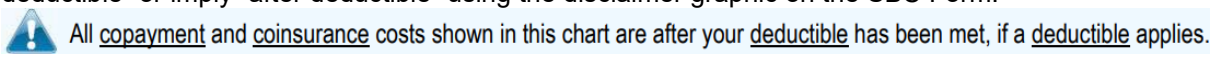
* The PY24 SBC URL Review shall focus on these benefits, including MOOPs and deductibles. SBC

Review Guidance

- **SBC URLs Are Direct:**
  - If the QHP SBC URL does not lead directly to the SBC Form, the SBC is flagged for required corrections
    - Consumers must 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 is flagged for required corrections:
    - SBC Form submitted in portrait orientation (cannot read from top to bottom)
    - A watermark placed over cost sharing information
    - Plans covering multiple tiers, but lacking Tier 2 information
    - Merged individual benefits
    - Merged cost sharing data
    - Merged data across fields
    - Modified Benefit Names

- As specified in the Instructions for Completing the SBC, please note the following instructions for the "What you will pay" columns:
  - Issuers can vary the number of columns depending on the type of coverage and the number of preferred provider networks. Most policies with a network use two columns, although some policies with more than one level of in-network provider use three columns. Non-networked plans can use one column.
  - Denote exceptions in these columns, such as when a specific service is subject to a separate deductible or is covered at no cost.
  - Insert the terminology from the policy or plan document in the title columns. For example, call columns "Network Provider" and "Out-of-Network Provider" or "Preferred Provider" and "Non-Preferred Provider" based on the terms used in the policy. Delete the subheadings for non-networked plans with only one column.
  - Order the columns from left to right, from most generous cost sharing to least generous cost sharing. For example, if a three-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, including 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, note the allowed dollar amounts in the SBC Form.
    - Acceptable: **"$70 Allowance available for glasses/lenses"**
    - Unacceptable: **"Allowances available for glasses/lenses"**
- **Match the Plans & Benefits Template to 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 a 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.
  - Example 1: Acceptable with disclaimer graphic
    - 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, with issuers including 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 cannot state "HDHP" but can use "HDHP HMO" or "HMO" instead.
- **Use Consistent Copay Application ("Per Stay" or "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" can 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, can 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 greater than what would be imposed if services were provided in network.
  - Check the SBC Form and Plans & Benefits Template for correct and consistent listing of cost-sharing in both places.

Plan Brochures

45 CFR 155.205 contains regulations related to the plan brochure URL. The Instructions for the Plans and Benefits Application Section offers guidance.

- Align benefits coverage and cost-sharing information in the plan brochure with the information in the Plans & Benefits Template. Check general plan information and in-network and out-of-network cost-sharing for consistency with the information in the template.

- 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, communicate further details on these cost-sharing differences through the plan brochure. Review their plan brochures to ensure such details are clearly communicated for all benefits to which they apply.
- Direct consumers to the correct language version of their plan brochure document (e.g., English vs. Spanish).

Provider Directory

45 CFR 156.230(b) contains regulations related to the provider directory. The Instructions for the Network Identification Application Section offer additional guidance.

- Include all information required by 45 CFR 156.230(b), such as contact information, specialty, whether the provider is accepting new patients, and whether the provider is in-network. Review provider directories to make sure these fields display and that a process is in place to update them regularly.
- Issuers who maintain multiple provider networks must make it easy to discern which providers participate in which plans and which provider networks; network name does not display on HealthCare.gov, so do not require consumers to know in which network they are located. Verify that a consumer can discern whether 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.
- Make provider directories easy to access from the provider directory URL and the issuer's home page without creating or accessing an account or entering a policy number. Ensure consumers can easily find the provider directory via the submitted URL.

Formulary

45 CFR 147.200(a)(2)(i)(L) contains regulations related to the formulary. The Instructions for the Prescription Drugs Application Section offer additional guidance.

- Through formulary URLs, direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, specific to a given QHP. Verify that these fields are readily visible on the online formulary.
- Link formulary URLs 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. Ensure that none of this information is required to view the online formulary.
- If an issuer has multiple formularies, be clear about which formulary applies to which QHPs. Check that a consumer can reasonably identify whether a drug is covered for a particular plan without any information beyond the URL and the fields that display on HealthCare.gov.
- 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) 2024 agreement signing deadline, issuers must have an active PY2023 formulary for the current plan year that was marked as a PY2023 Formulary and an active PY2024 formulary for the upcoming plan year that was marked as a PY2024 Formulary.
- The Formulary Data Integrity review compares the data (drug coverage, tier assignments, step therapy and prior authorization restrictions) that issuers have submitted in their Prescription Drug template as part of the QHP application process and the data displayed on the issuers' online formulary accessed via the formulary URL.

Payment

The Instructions for the Plans and Benefits Application Section offers guidance on payment URLs.

Link payment URLs directly to a working payment site capable of collecting a consumer's first-month premium and which complies with the latest payment redirect business service description (optional for stand-alone

dental plans). Confirm that 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

45 CFR 155.1040(a) and 156.220 contain regulations related to Transparency in Coverage. The Instructions for the Transparency in Coverage Application Section offers additional guidance.