

Qualified Health Plan Issuer Application Instructions

2018

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Version 1

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Introduction: Qualified Health Plans for 2018

As defined in the Affordable Care Act (ACA), a qualified health plan (QHP) is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits (EHBs), follows established limits on cost sharing, and meets several other requirements.

For an insurance plan to be certified as a QHP, issuers must complete and submit a QHP Application for each plan they intend to offer on the Federally-facilitated Marketplace (FFM).

Overview of the QHP Certification Process

Issuers must annually complete the application and certification process. To facilitate this process, issuers are encouraged to read the following published guidance:

- Each year, the Centers for Medicare & Medicaid Services (CMS) publishes a [Letter to Issuers](#) before the certification process. This letter provides guidance for issuers seeking to offer QHPs, including stand-alone dental plans (SADPs) in the FFMs or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs).
- In addition to the Letter to Issuers, CMS provides a [Notice of Benefit and Payment Parameters](#) and a [final rule for Exchange and Insurance Market Standards](#) for 2015 and beyond. The notice sets payment parameters that apply to the benefit year and proposes new standards to improve consumers' Marketplace experience. The final rule for Exchange and Insurance Market Standards finalizes policies regarding consumer notices, quality report and enrollee satisfaction survey, the Small Business Health Options Program (SHOP), standards for navigators and other consumer assisters, and the premium stabilization programs, among other standards. CMS issued a Market Stabilization Rule for 2018 in April of 2017. **The Market Stabilization rule includes changes to special enrollment periods, the annual open enrollment period, network adequacy rules, qualified health plan (QHP) review, and actuarial value (AV) requirements.**

CMS also provides a variety of other guidance on the [Health Insurance Market Reforms](#), and on the [Health Insurance Marketplaces](#) in general.

Table 1 shows the timeline for the 2018 QHP Application certification process, as detailed in the Letter to Issuers.

NOTE: All dates are subject to change.

Table 1. 2018 QHP Application Timeline

Activity		Date
QHP Application Submission and Review Process	Initial QHP Application Submission Window ¹	5/10/2017–6/21/2017
	CMS reviews initial QHP Application as of 6/21/2017	6/22/2017–7/25/2017
	CMS sends first correction notice	8/1/2017–8/2/2017
	Deadline for Service Area Petition	8/4/2017
	Final deadline for issuer changes to QHP Application	8/16/2017
	CMS reviews final QHP submission as of 8/16/17	8/17/2017–9/11/2017
	CMS sends final correction notice to issuers, with agreements for signature and plan lists for confirmation	9/14/2017–9/15/2017
	States send CMS final plan recommendations	9/27/2017 ²
QHP Agreement/ Final Certification	Issuers send signed agreements, confirmed plan lists, and final Plan Crosswalks to CMS	9/16/2017–9/27/2017
	CMS sends certification notices with countersigned agreements and final plan lists to issuers ³	10/11/2017–10/12/2017
	Limited data correction window: outreach to issuers with CMS- or state- identified data errors; issuers submit corrections; CMS reviews and finalizes data for Open Enrollment	9/15/2017–10/7/2017
Open Enrollment		Begins on 11/1/2017

QHP Application Submission Process

Beginning in May, issuers should submit their templates and supporting documentation and justifications for all plans they intend to have certified as part of their QHP Application. CMS requires issuers, including those offering SADPs, to submit a completed QHP Application by the initial submission deadline on June 21, 2017, and to make necessary updates before the final data submission deadline on August 16, 2017.

¹ Unified Rate Review Template (URRT) and Form Filing submissions to CMS in States in which CMS is either the Effective Rate Reviewer or direct enforcer of the Affordable Care Act federal reforms follow the same Initial Submission Window and Deadline as the QHP Initial FFM QHP Application Submission Window. This submission deadline applies to URRT and Form Filing submissions for single risk pool coverage (including QHPs and non-QHPs).

² Separate from Correction Notices, CMS will send plan lists for confirmation to States with an FFM, including FFMs in States performing plan management functions, and to States with SBM-FPs. CMS requires responses to that State outreach by September 27, 2017, including notification of any plans transferred in error or a State otherwise recommends against (for FFMs) or denies (SBM-FPs) certification of a plan. States must communicate that information to CMS in order for the information to be incorporated into certification decisions and Certification Notices, as applicable.

³ CMS plans to send countersigned agreements with the Certification Notices for plan year 2018 (CMS will not send Validation Notices, as was done in previous certification cycles).

CMS relies on a number of systems to automate the data collection and validation process. Issuers use different systems to submit their QHP Application materials, depending on the Marketplace model to which their state belongs.

Issuers can reference a list of [Submission Systems](#) for information on the system in which issuers should file their QHP Applications and supporting data.

Issuers may also be required to submit data to their state. Some FFM states use the System for Electronic Rate and Form Filing (SERFF) to collect plan data, which may include copies of the QHP templates, but any data submitted into SERFF by issuers applying for QHP certification in FFM states will not be transferred to CMS. Issuers should ensure that changes to plan data are submitted to CMS—via the Health Insurance Oversight System (HIOS)—and as required by their state.

HIOS

Issuers in FFM states submit their QHP Application materials through HIOS, but all issuers, except those in State-based Marketplaces (SBMs), need to register with HIOS to obtain a HIOS Issuer ID and record issuer administrative contact information. In addition, states performing plan management functions submit all rate filing information through HIOS. Refer to the [HIOS Quick Reference Guide](#) and [HIOS Portal User Manual](#) for more information on registering and navigating through the portal.

The HIOS Modules to be completed are as follows:

- **Issuer Module:** This is where FFM issuers submit, review, and modify QHP Application data related to their business processes. The Issuer Module consists of sections that are accessible through tabs to submit the [templates and documentation](#). Refer to the [Issuer Module User Guide](#) for detailed instructions.
- **Benefits and Service Area Module:** This is the module FFM issuers use to submit, review, and modify QHP Application data pertaining to the benefits, service areas, provider networks, and prescription drugs for each of the plans they intend to offer. The module allows issuers to submit all necessary information using a web-based user interface and Microsoft Excel templates. Refer to the [Benefits and Service Area Module User Guide](#) for detailed instructions.
- **Rating Module:** This is where issuers in FFM states and states performing plan management functions provide rating data information for the plans they intend to offer, to determine the plans' premiums and benefits cost for consumers in a given Marketplace or set of Marketplaces. Refer to the [Rating Module User Guide](#) for detailed instructions.
- **Unified Rate Review System Module:** This is where all QHP applicants provide the data required to review rate increases and ensure issuers' compliance with the single risk pool and allowable market-level index rate adjustments to reflect reinsurance and risk adjustment. Refer to the [Unified Rate Review System Module User Guide](#) for detailed instructions.

Issuers can also use HIOS to access Plan Preview, a tool that displays plan and issuer data similarly to the way they display on Plan Compare on HealthCare.gov. Issuers can refer to the [Plan Preview Module User Guide](#) for more information.

Table 2 lists the modules with their associated forms and templates that need to be completed in that section.

Table 2. Modules, Associated Forms, and Templates

HIOS QHP Application Module	Description
Issuer Module	Focuses on the issuer-level QHP certification requirements. Contains the following QHP Application sections: <ul style="list-style-type: none"> ◆ Program Attestations ◆ State Licensure ◆ Good Standing ◆ Accreditation ◆ Essential Community Providers/Network Adequacy
Benefits and Service Area Module	Includes QHP Application sections related to plan-level QHP certification requirements. Contains the following QHP Application sections: <ul style="list-style-type: none"> ◆ Network ID ◆ Service Area ◆ Prescription Drugs ◆ Plans & Benefits

HIOS QHP Application Module	Description
Rate Module	Includes QHP Application sections related to plan rates: <ul style="list-style-type: none"> ◆ Rates Table ◆ Business Rules
Unified Rate Review Module	Unified Rate Review

SERFF

Issuers in states performing plan management functions and SBM(s) on the Federal Platform (SBM-FP) submit their QHP Application through SERFF. Issuers need to contact their state for any additional application requirements.

Questions related to SERFF functionality should be directed to the SERFF Help Desk at serffhelp@naic.org. For information about state systems, issuers should contact the relevant state.

QHP Application Sections and Associated Templates

Most sections of the QHP Application require the submission of Excel templates that contain issuer and plan data. Table 3 lists all required templates according to where they appear in the QHP Application submission process.

Table 3. Required Templates

HIOS Module	Application Area	Template
Issuer Module	Administrative	No template—complete <i>Issuer General Information</i> fields and the <i>Marketplace General Information</i> fields in the HIOS Plan Finder Module
Issuer Module	Program Attestations	No template—FFM issuers respond to attestations in the HIOS Issuer Module Issuers in FFM states performing plan management functions submit the State Partnership Marketplace Issuer Program Attestation Response Form in SERFF
Issuer Module	State Licensure	No template—respond to attestations and upload state licensure documentation in the HIOS Issuer Module
Issuer Module	Good Standing	No template—respond to attestations and, if necessary, upload documentation in HIOS Issuer Module
Issuer Module	Accreditation	NCQA Template URAC Template AAHC Template
Issuer Module	Essential Community Providers/Network Adequacy	Essential Community Providers/Network Adequacy Template
Benefit and Service Area Module	Network ID	Network ID Template
Benefit and Service Area Module	Service Area	Service Area Template
Benefit and Service Area Module	Prescription Drugs	Prescription Drug Template

HIOS Module	Application Area	Template
Issuer Module	Administrative	No template—complete <i>Issuer General Information</i> fields and the <i>Marketplace General Information</i> fields in the HIOS Plan Finder Module
Benefit and Service Area Module	Plans & Benefits	Plans & Benefits Template Plans & Benefits Add-In Plans & Benefits Add-In Change Log Simple Plan Design Add-In
Rate Module	Rates	Rates Template
Rate Module	Business Rules	Business Rules Template
Unified Rate Review Module	Unified Rate Review	Unified Rate Review Template
	Plan ID Crosswalk	Plan ID Crosswalk Template

Supporting Documentation

Issuers may also be asked to submit supporting documentation and justifications as part of the QHP Application process. **Note:** Not all QHP Application sections require the submission of supporting documentation or justifications.

Table 4 lists the supporting documentation and justifications in each application section; it also includes a description of the files, the submission criteria that determine whether an issuer must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention to be used by issuers when naming the supporting documentation or justification.

Table 4. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
SPM Issuer Program Attestation Response Form (only for issuers in FFM states performing plan management functions)	Provides attestations for issuers in FFM states performing plan management functions who are not able to respond to attestations via HIOS.	Required for all issuers in FFM states performing plan management functions (see Section 1: Program Attestation).	Attestation	12345_SPMIssuerAttestations
Compliance Plan	Provides documentation that the issuer has a compliance plan that adheres to all applicable laws, regulations, and guidance; that the compliance plan is ready for implementation; and that the issuer agrees to reasonably adhere to the compliance plan provided.	Required if a Yes response is provided to the Optional Program Attestation (see Section 1: Program Attestation).	Attestation	12345_CompliancePlanandCover Sheet.pdf

Table 4. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Compliance Plan and Organizational Chart Cover Sheet	Accompanies issuer's compliance plan and identifies the page numbers where the required compliance plan elements are found.	Required if a Yes response is provided to the Optional Program Attestation (see Section 1: Program Attestation).	Attestation	12345_CompliancePlanandCoverSheet.pdf
Organizational Chart	Provides documentation that the issuer has an organizational chart.	Required if a Yes response is provided to the Attestations required of both Medical QHP and SADP issuers (see Section 1: Program Attestation).	Attestation	12345_OrganizationalChart.doc
Licensure Documentation	Provides documentation that the issuer is licensed.	Required if a Yes response is provided to Questions 1 or 2 in the HIOS interface (see Section 1: State Licensure).	State Licensure	12345_CertificateofCompliance or 12345_COA or 12345_StateLicense
Good Standing Supplemental Response	Describes how the issuer intends to comply with state solvency standards and provides a justification for noncompliance that explains the conditions that caused the issuer to become financially insolvent.	Required if a Yes response is provided to Question 1 in the HIOS interface (see Section 1: Good Standing).	Good Standing	12345_GoodStandingSupplementalResponse
Corrective Action Plan	Describes how the issuer intends to respond to corrective actions and provides a justification that explains how a corrective action plan or equivalent document will address the issues identified by the state.	Required if a Yes response is provided to Question 2 in the HIOS interface (see Section 1: Good Standing).	Good Standing	12345_CorrectiveActionPlan
Accreditation Certificate	Demonstrates that the issuer is accredited.	Required for all accredited issuers except those participating for their fifth consecutive year.	Accreditation	[HIOS Issuer ID]_[Name of Accrediting entity]

Table 4. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Essential Community Providers Supplemental Response	Describes why the issuer cannot meet the ECP requirements. Justifications for medical ECPs and dental ECPs have different requirements.	For medical ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area; that do not offer a contract to all Indian health providers in the service area, and that do not offer a contract to at least one ECP in each available ECP category in each county in the service area. For dental ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area and that do not offer a contract to all Indian health providers in the service area.	ECP/ Network Adequacy	12345_ECP_supplemental_response Dual product issuers should submit two files with the following naming conventions: <ul style="list-style-type: none"> • 12345_ECP_supplemental_response_QHP • 12345_ECP_supplemental_response_SADP
Access Plan and Cover Sheet	Cover Sheet and Access Plan that addresses and references the 11 areas in the Supporting Documentation table under Section 1E: Essential Community Providers/Network Adequacy. Recommend the Cover Sheet be inserted in front of the Access Plan (as opposed to being a separate document).	QHPs and SADPs that need to submit access plans will be notified directly by email	ECP/ Network Adequacy	12345_Access_Plan 12345_Access_Plan_Cover_Sheet (if Cover Sheet is submitted as a separate document)
Service Area Partial County Supplemental Response	Describes why the issuer cannot provide service to an entire county.	Required if issuer is requesting a partial county service area.	Service Area	12345_XY_service_area_partial_county
Combined Prescription Drug Supporting Documentation and Justification	Identifies reasons why deficiency occurs in Clinical Appropriateness, Formulary Outlier or in Category/Class Benchmark Count and how they are not discriminatory.	Required if a deficiency occurs in Clinical Appropriateness, Formulary Outlier or in Category/Class Benchmark Count.	Prescription Drug	12345_XY_combined_drug

Table 4. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Discrimination —Treatment Protocol Supporting Documentation and Justification	Identifies reasons why a drug list may be an outlier in terms of out-of-pocket cost but is not discriminatory.	Required if out-of-pocket cost is determined to be an outlier.	Prescription Drug	12345_XY_treatment_protocol
Discrimination —Language Supporting Documentation and Justification	Identifies reasons why language identified as discriminatory is not.	Required if language is found to be discriminatory.	Plans & Benefits	12345_XY_discrimination_language
Discrimination —Cost-Sharing Outlier: Supporting Documentation and Justification	Identifies reasons why cost-sharing values found to be outliers should be allowed and are not discriminatory.	Issuers submit in HIOS when the cost-sharing values are identified as outliers at the national and state levels and remain uncorrected; SERFF submission requirements depend on the State.	Plans & Benefits	12345_XY_discrimination_cost_sharing
Meaningful Difference Supporting Documentation and Justification	Identifies reasons why the plans are meaningfully different.	Required for issuers that fail meaningful difference review.	Plans & Benefits	12345_XY_meaningful_difference
Unique Plan Design Supporting Documentation and Justification	Describes the reasons that a plan qualifies as unique (it is not compatible with the standard Actuarial Value Calculator) and the methods used to calculate actuarial value (AV).	Required if <i>Unique Plan Design?</i> is Yes .	Plans & Benefits	12345_XY_unique_plan_design
Silver/Gold Supporting Documentation and Justification	Identifies reasons why silver/gold plan requirement is not met.	Required for issuers that fail silver/gold plan review.	Plans & Benefits	12345_XY_silvergold
EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification	Identifies EHB benchmark benefits that have been substituted, the substituted benefits, and the associated values of each.	Required if <i>EHB Variance Reason</i> is Substituted .	Plans & Benefits	12345_XY_EHB_substituted_benefit.doc

Table 4. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification	Describes the methods used to calculate AV.	Required for all SADP issuers.	Plans & Benefits	12345_XY_SADP_actuarial_value
Stand-Alone Dental Plan—Description of EHB Allocation	Details the methods and specific analysis used to determine the EHB apportionment for pediatric dental.	Required for all SADP issuers.	Plans & Benefits	12345_XY_description_EHB_allocation
Quality Improvement Strategy (QIS)	QHP issuer participating in a Marketplace for 2 or more consecutive years that offers family and/or adult-only medical coverage and meets the QIS minimum enrollment threshold.	Required for all issuers offering QHPs through a Marketplace, whether through the individual market or through the SHOP Marketplace.	The technical guide may be found here	[HIOS Issuer ID]-[Issuer Name]-QIS If submitting more than one QIS: [HIOS Issuer ID]-[Issuer Name]-QIS-[#]

Saving Supporting Documents

Issuers should save supporting documentation and justifications using the file-naming conventions in the last column of the table above. When saving the file, do not include spaces in the file name. A period, a hyphen, and an underscore are the only special characters that can be used for a file name. The file name may include both lowercase and capital letters, and its full path length must not exceed 255 characters if the file is being uploaded to HIOS. The following document formats should be used when uploading supporting documentation and justifications: **.doc; .docx; .pdf.**

Uploading Supporting Documents

Issuers are encouraged, when possible, to upload one version of the supporting documentation and justifications. For example, when the supporting documentation or justification reasoning is the same for multiple products or plans for a particular application section, the products and plans can be listed in one document.

Review Periods, Revision Process, and Certification

After the close of the initial QHP Application submission window, there will be two review periods during which issuers' QHP Applications are checked for compliance with market-wide standards and other regulations.

Following each review period, CMS will send applicants notices summarizing any need for corrections identified during CMS's review. For issuers applying to offer one or more QHPs on-Marketplace, these notices will also include critical data errors. Revisions and corrections to the QHP Application will be accepted only between correction notices and the deadlines for resubmission. If an issuer finds an error in its documentation before a correction period, it must wait until after correction notices are sent out. The correction notices will provide detailed information regarding which section in the application the error has been found. Further, it will describe how the correction(s) should be addressed to eliminate the error.

After each round of review, issuers will be able to make necessary changes to their QHP Applications, including as a response to their notices, and upload revised QHP data templates. After the final data submission deadline and the final review, CMS will conduct outreach to issuers that are required to enter the limited data correction

window to correct critical data errors before Open Enrollment. However, CMS expects data submitted by the final submission deadline to be accurate and complete, and any data changes for inaccurate application data will result in a notice of non-compliance. Errors and corrections must be addressed before the affected QHPs may be certified and/or displayed on HealthCare.gov.

CMS's certification determination for the plans listed in the issuer's application is based on the information contained in the application. CMS reserves the right to revisit the certification status of any plan if there are any changes to the information an issuer supplied during the application process. Issuers must notify CMS of any changes to their QHP Application. Issuers' plan(s) may be decertified during the plan year if CMS determines that any of the information contained in the issuer's application is inaccurate or incomplete, or that it no longer meets all applicable certification standards, other program requirements, or both.

Please also be advised that CMS may contact issuers at any time as part of CMS's routine monitoring of issuers to ensure ongoing compliance with certification standards and other program requirements. These standards and requirements remain in place throughout the entire plan year.

The determinations described above are based solely on CMS's review of the application for each plan's compliance with QHP certification standards, along with any information received by CMS from the applicable state regulator, including appropriate state approvals. Nothing in the determinations relieve issuers of QHPs/SADPs from the obligation to comply with all applicable state and federal requirements.

Service Area Petition Process

After June 21, 2017, issuers cannot make changes to their service area, including as a response to a CMS- or state-identified correction, without first submitting a petition. Changes to the service area may not be made in the QHP Application unless the petition is approved.

Any change to the name of the service area or list of counties associated with a particular plan is considered a change in the service area, even if the issuer offers other plans or products in the counties (or partial counties) in question. Issuers should note that while any changes to the Service Area Template (including changing the name of the service area) necessitate a petition, a change in service area is not always directly related to changes made to this template. That is, a change to the Plans & Benefits Template may also potentially affect the service area. For example, changing the service area ID associated with a plan from S001 to S002 constitutes a change to service area. Any such changes made after June 21, 2017, also necessitate a petition.

Requests from FFM issuers must be submitted by **August 4, 2017**, to allow sufficient time for review. Issuers in FFM states performing plan management functions should contact their states to identify the petition submission deadline. All issuers must submit changes to their QHP Applications after the petition(s) are approved and before the final data submission deadline of August 16, 2017.

The required forms are located at: <https://www.qhpcertification.cms.gov/s/Service%20Area>

Issuers in Federally-facilitated Marketplace (FFM) States

Issuers submitting a petition to change their Service Area template data must submit the following documentation:

- State Authorization of QHP Change Request Plan Year 2018 (PY2018),
 - Issuers in states where CMS directly enforces the provisions of the Affordable Care Act should provide evidence of approval by CMS Form Filing
- QHP Application Data Change Request Form PY2018,
- Supplement A to the Data Change Request Form PY2018, and
- Supplement B to the Change Request Form PY2018.

Issuers should submit the above completed forms to the Exchange Operations Support Center (XOSC) Help Desk at CMS_FEPS@cms.hhs.gov. CMS will deny any data change request that does not include the above required elements.

Issuers in FFM States Performing Plan Management Functions

Issuers should work directly with state regulators to request and gain approval for changes to service area data. Issuers are encouraged to use the following forms when submitting a petition to the state:

- QHP Application Data Change Request Form PY2018,
- Supplement A to the Data Change Request Form PY2018, and
- Supplement B to the Change Request Form PY2018.

Issuers should submit the above completed forms to the state. CMS will work with the state and the state will either approve or deny the petition.

Issuers in State-based Marketplaces using the Federal Platform

- Issuers in State-based Marketplaces using the Federal platform should follow their state's guidance on changes to service area.

Data Integrity Tool and Review Tools

CMS provides issuers with a number of review tools to check their plans for errors in the QHP Application that would result in correction notices following submission. Issuers should run each of the below tools, as applicable to their issuer type (e.g. SADP/QHP) before uploading materials to HIOS or SERFF to identify and correct data errors. Given the limited review cycle, it is critical that issuers use the tools to ensure that all data submitted is free of errors so that their plans will be reviewed for certification on time. Table 4 provides a high-level description of each tool's functionality.

Table 5. High-level Description of Each Tool's Functionality

Tool	Purpose
Data Integrity Tool*	Identifies critical data errors within and across templates. Provides immediate feedback about data, reducing issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports QHP and SADP data from most application templates. Conducts validation checks beyond the standard HIOS and SERFF checks. Looks across templates for consistency in key fields. Produces error reports that describe the error and its location in the template.
Plan ID Crosswalk Tool*	Checks that the Plan ID Crosswalk Template has been completed accurately, by ensuring that all counties in all FFM plans that were offered in 2017 are included in the crosswalk, the plans are crosswalked to valid 2018 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 Code of Federal Regulations (CFR) 155.335(j).
Master Review Tool*	Aggregates data from the Plans & Benefits, Service Area, and ECP/Network Adequacy, and Prescription Drug Templates and serves as a data input file to the other stand-alone tools.
Essential Community Providers (ECPs) Tool	Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.

Table 5. High-level Description of Each Tool’s Functionality

Tool	Purpose
SADP Essential Community Providers (ECPs) Tool*	Calculates the total number of ECPs an issuer has in each plan's network and compares this to the number of available ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.
Meaningful Difference Tool	Performs the "Supporting Informed Consumer Choice" review as discussed in regulation and the 2018 Letter to Issuers. It compares all plans an issuer offers to check whether there are multiple plans in the same county that would appear virtually identical to a consumer.
Non-Discrimination Tool	Performs an outlier analysis for "QHP Discriminatory Benefit Design" as discussed in the 2018 Letter to Issuers. It looks at all plans in the state, goes through a group of pre-determined benefits, and determines if any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
Cost Sharing Tool*	Runs five different checks (when they are applicable to the plan) for cost sharing standards. This includes Maximum Out-of-Pocket (MOOP) Review, Cost Sharing Reduction (CSR) Plan Variation Review, Simple Choice Plan Design Review, Expanded Bronze, and Catastrophic Plan Review.
Category & Class Drug Count Tool	Compares the count of unique chemically distinct drugs in each USPv6 category and class for each drug list against a state's benchmark.
Formulary Review Suite: Non-Discrimination Formulary Outlier Review	Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization and/or step therapy requirements in 27 USP classes.
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with nine conditions as recommended in clinical guidelines, to ensure that issuers are offering a sufficient type and number of drugs.

* Indicates tools that apply for SADP issuers

Stand-alone Dental Issuers

An issuer that participates solely in the dental market—a dental-only issuer—or one that participates in both the medical and dental markets—a dual product issuer—may offer SADPs. SADP issuers are required to complete a subset of the entire QHP Application.

Table 6 lists each of the application sections, templates, and supporting documentation that apply to SADP issuers, and in which section their instructions can be found.

Table 6. Instruction Location for Application Sections

Application Section	Instruction Section	Documents Required for SADP Issuers?
Administrative	HIOS Plan Finder Only (no section instructions)	Yes—Complete <i>Issuer General Information Fields</i> and the <i>Marketplace General Information Fields</i> in the HIOS Plan Finder Module
Program Attestation	Section 1: Program Attestation	Yes—Attestations in HIOS
State Licensure	Section 1: State Licensure	Yes—Supporting documentation
Good Standing	Section 1: Good Standing	Yes—Supporting documentation

Accreditation	Section 1: Accreditation	Not required
ECP/Network Adequacy	Section 1: ECP/Network Adequacy	Yes—Template
Network ID	Section 2: Network Identification	Yes—Template
Service Area	Section 2: Service Area	Yes—Template
Prescription Drug	Section 2: Prescription Drug	Not required
Plans & Benefits	Section 2: Plans & Benefits	Yes—Template
Business Rules	Section 3: Business Rules	Yes—Template
Rates Table	Section 3: Rates Table	Yes—Template
Actuarial Value Calculator	Appendix 1: Actuarial Value Calculator	Not required

Pediatric dental is an EHB that must be offered by all issuers in the individual and small group markets. If the pediatric dental benefits are covered by an SADP on the Marketplace, QHPs in that state are not required to offer the pediatric dental EHBs on the Marketplace.

Dental-only issuers and dual product issuers should use either HIOS or SERFF, as applicable, to complete the relevant application sections and templates.

Issuer Module

Users of the Issuer Module are assigned to one or both of the following roles: Issuer Submitter, an individual who submits the data necessary to complete the Issuer Module, and Issuer Validator, an individual who will verify that all sections of the Issuer Module are accurate.

This module is divided into various sections with tabs to navigate through the sections listed on the top of the page. There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (see Figure 1-1).

Figure 1-1. Three Module Tabs



The Data Submitter page allows Submitters to work on an existing application or view an already-submitted application.

The Data Validator page allows Validators to view a list of all the applications that have been submitted. This section also allows validators to upload supporting documentation and answer supplemental responses through HIOS.

The Final Submission page allows users to cross-validate data between modules and submit the QHP Application.

Each of these tabs are broken down further with information that needs to be entered to create a new application or edit an existing application. For the Data Submitter page, all sections listed on the left-hand side of the page will need to be completed before moving on to the Data Validator page (see Figure 1-2).

Figure 1-2. Data Submitter Page Selection List



Users can navigate to the Review page at any time using the left navigation links during the submission process. The Review page shows a table listing all sections of the application, last modified date, and the name of the user that last modified the section (see Figure 1-3). The same applies to the Validator page (Figure 1-4).

Figure 1-3. Review Page Snapshot

Data Submitter Data Validator Final Submission

 You have successfully submitted this application

All sections must be completed to the best of your knowledge before being submitted.

Submitter Sections Table

Application Sections	Modified Date	Modified By	Status
Admin Data	02/11/2015 11:10:51 AM	TEST193@FFETEST.COM	Submission Completed
Program Attestations	02/11/2015 11:10:35 AM	TEST193@FFETEST.COM	Submission Completed
State Licensure	02/11/2015 11:11:20 AM	TEST193@FFETEST.COM	Submission Completed
Good Standing	02/11/2015 11:26:20 AM	TEST193@FFETEST.COM	Submission Completed
Accreditation	02/11/2015 11:26:26 AM	TEST193@FFETEST.COM	Submission Completed
Network Adequacy	02/11/2015 11:26:34 AM	TEST193@FFETEST.COM	Submission Completed
Essential Community Providers	02/11/2015 11:26:54 AM	TEST193@FFETEST.COM	Submission Completed

Figure 1-4. Validator Sections Table

Data Submitter Data Validator Final Submission

All sections must be completed to the best of your knowledge before being submitted.

Validator Sections Table

Application Sections	Modified Date	Modified By	Status
Admin Data	02/11/2015 11:10:51 AM	TEST193@FFETEST.COM	Validation Passed
Program Attestations	02/11/2015 11:10:35 AM	TEST193@FFETEST.COM	Validation Passed
State Licensure	02/11/2015 11:11:20 AM	TEST193@FFETEST.COM	Validation Passed
Good Standing	02/11/2015 11:26:20 AM	TEST193@FFETEST.COM	Validation Passed
Accreditation	02/11/2015 11:26:26 AM	TEST193@FFETEST.COM	Validation Passed
Network Adequacy	02/11/2015 11:26:34 AM	TEST193@FFETEST.COM	Validation Passed
Essential Community Providers	02/11/2015 11:26:54 AM	TEST193@FFETEST.COM	Validation Passed

[Return to Submitter](#) [Previous](#) [Submit Application](#)

Section 1A: Program Attestations

1. Introduction

In the Program Attestations section, issuers must respond to attestations regarding the intent to comply with FFM requirements. For 2018, the program attestations section of the Issuer Module has been updated to include the following four subsections of attestations (in order): QHP and SADP Attestations, Medical QHP-only Attestations, SADP-only Attestations, and Optional Attestations. These instructions only apply to FFM issuers filing through HIOS.

Issuers in FFM states performing plan management functions need to complete and submit the State Partnership Marketplace Issuer Program Attestation Response Form through SERFF. The 2018 State Partnership Marketplace Issuer Program Attestation Response Form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations>.

2. Data Requirements

To complete this section, issuers need the following information:

1. Company organizational chart: Save the organizational chart using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_OrganizationalChart.doc."
2. Company compliance plan.
3. Compliance Plan and Organizational Chart Cover Sheet: The 2018 Compliance Plan and Organizational Cover Sheet is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations> Application Areas and Templates.
 - a. To add the Compliance Plan and Organizational Chart Cover Sheet PDF into an existing compliance plan PDF file, use the Document/Insert Pages function in Adobe Acrobat.
 - b. Merge the Compliance Plan and the Compliance Plan Cover Sheet into a single PDF file and save the document using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_CompliancePlanandCoverSheet.PDF."
4. Justification Form, applicable only to those issuers attesting "No" to the compliance plan optional attestation. A blank justification form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations> Application Areas and Templates. Save the justification form using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_ComplianceJustificationForm.PDF."
5. State Partnership Marketplace Issuer Program Attestation Response Form: Applicable only to issuers in FFM states performing plan management functions submitting in SERFF. The 2018 State Partnership Marketplace Issuer Program Attestation Response Form is available at <https://www.qhpcertification.cms.gov/s/Program%20Attestations> Application Areas and Templates. Save the form using the following naming convention: [HIOS Issuer ID]_[SPMIssuerAttestations]. For example: "12345_SPMissuerAttestations.PDF."

3. Quick Reference

Key Changes for 2018
<ul style="list-style-type: none"> ◆ The FFM Issuer Attestations: Statement of Detailed Attestation Responses has been removed. All FFM issuers will now complete all attestations in HIOS only. ◆ The attestation language has been reorganized and streamlined. ◆ The program attestations section of the HIOS Issuer Module has been updated to include four subsections: Attestations required of both QHP and SADP issuers, Attestations required of Medical QHPs only, Attestations required of SADPs only, and Optional Attestations. ◆ All issuers are required to provide a response to each of the four subsections regardless of the certification type for which they are submitting. ◆ All issuers are required to upload documents depending on responses to the attestations. ◆ Issuers responding “No” to the optional compliance plan attestation are required to upload a justification form. ◆ The justification form is only for FFM issuers using HIOS.

Tips for the Program Attestations Section
<ul style="list-style-type: none"> ◆ Issuers must respond to <u>all</u> attestation subsections. ◆ Medical QHP-only issuers may respond “Not Applicable (NA)” to the SADP-only program attestations subsection. SADP-only issuers may respond “Not Applicable (NA)” to the Medical QHP-only program attestations subsection. ◆ All issuers, including those submitting only medical QHPs, only SADPs, or both, are encouraged to respond “Yes” to the compliance plan optional attestation and upload a compliance plan and the Compliance Plan and Organizational Chart Cover Sheet.

4. Detailed Section Instructions

All issuers and their affiliates seeking to participate in the FFM, including SADP issuers, must complete all the program attestations subsections of the application. To complete this section, issuers must respond to all the program attestations subsections and, as applicable, upload supporting documentation or justifications.

Attestation Area	Steps
Program Attestations required of both Medical QHP and SADP issuers	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> ◆ Yes—if the issuer agrees to the listed issuer attestation. If Yes is selected, issuers are required to submit the Organizational Chart. Use the document upload feature in the QHP and SADP Attestations subsection and select “Organizational Chart” as the document type. ◆ No—if the issuer does not agree to the listed issuer attestation. If No is selected, issuers may still submit an Organizational Chart or “Other” document. <p>Note: All issuers who wish to offer either certified QHPs or SADPs are required to respond “Yes.”</p>
Program Attestations required of Medical QHP issuers only	<p>Choose from the following to attest to the attestations in this section:</p> <ul style="list-style-type: none"> ◆ Yes—if the issuer agrees to the listed issuer attestation. ◆ No—if the issuer does not agree to the listed issuer attestation. ◆ Not applicable (NA)—if the issuer is not submitting for Medical QHP certification. <p>Note: Applicants applying to offer medical QHPs are required to respond “Yes” with regard to those medical QHPs. All applicants not applying to offer medical QHPs should select “NA” (not applicable).</p>

<i>Attestation Area</i>	<i>Steps</i>
Program Attestations required of SADP issuers only Program Attestations	Choose from the following to attest to the attestations in this section: <ul style="list-style-type: none"> ◆ Yes—if the issuer agrees to the listed issuer attestation. ◆ No—if the issuer does not agree to the listed issuer attestation. ◆ Not applicable (NA)—if the issuer is not submitting for SADP certification. <p>Note: Applicants applying to offer SADPs are required to respond “Yes” with regard to those SADPs. All applicants not applying to offer SADPs should select “NA” (not applicable).</p>
Optional Program Attestations	Choose from the following to attest to the attestations in this section: <ul style="list-style-type: none"> ◆ Yes—if the issuer agrees to the listed compliance plan attestation. If Yes is selected, submit the Compliance Plan and the Compliance Plan and Organizational Chart Cover Sheet. Use the document upload feature in the Optional Attestations subsection and select “Compliance Plan” as the document type. ◆ No—if the issuer does not agree to the listed compliance plan attestation. If No is selected, complete and submit the justification form. Use the document upload feature in the Optional Attestations subsection and select “Other” as the document type. Issuers may still submit a Compliance Plan. <p>Note: CMS encourages all applicants, including those submitting medical QHPs, SADPs, or both to respond “Yes” and upload a Compliance Plan and the Compliance Plan Cover Sheet.</p>

The specific attestations for each of the four subsections are shown below.

<i>Attestation Area</i>	<i>Attestation</i>
Program Attestations required of both Medical QHP and SADP issuers	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 153, 155, and 156
Program Attestations required of Medical QHP issuers only	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 146, 147, 155, and 156.
Program Attestations of SADP issuers only	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 155 and 156.
Optional Program Attestations	Applicant attests that it is submitting a compliance plan that adheres to all applicable laws, regulations, and guidance, that the compliance plan is ready for implementation, and that the applicant agrees to reasonably adhere to the compliance plan provided. The applicant agrees to submit in advance any changes to the compliance plan to HHS for review. Applicant will upload a copy of the applicant’s compliance plan.

Issuers responding “No” to the optional attestation must provide a justification for why they are not attesting “Yes” to providing a compliance plan. A sample completed justification form looks like Figure 1A-1.

Figure 1A-1. Sample Completed Justification Form

Optional Program Attestation Justification for the Federally-facilitated Marketplace

Note: This form is only for FFM issuers who submit their QHP Application in HIOS. Issuers who apply via SERFF should submit a justification on the Statement of Detailed Attestations Responses form.

The compliance plan attestation is optional. CMS encourages all applicants, including those submitting only medical QHPs, only SADPs, or both, to respond “Yes” and upload a compliance plan and the compliance plan cover sheet in the Issuer Module.

If you responded “No” to the optional compliance plan program attestation, provide an explanation below:

Issuer is in the process of developing a compliance plan that will adhere to the laws, regulations and guidance. When the compliance plan is completed, it will be submitted to HHS.

Issuer name: Acme

HIOS ID: 12345

If this provides insufficient space to list your justifications, please print out another form and add additional reasons there.

Version 1

1

2018 Optional Program Attestation Justification

Issuers completing the Compliance Plan and Organizational Chart Cover Sheet should respond “Yes” or “No” to each evaluation criterion and should identify the applicable page number in the compliance plan where language supporting the evaluation criterion is found. Provide any organizational chart information requested on the same cover sheet.

CMS expects issuers to acknowledge that their compliance plans are applicable to Marketplace products and operations and to provide examples of specific plans or processes to comply with Marketplace requirements (see the “Compliance Plan Contents” section of the Compliance Plan and Organizational Chart Cover Sheet).

For example, issuers may have a Marketplace Module as a part of employees' compliance training, or they may develop audit plans to evaluate compliance risks in the Marketplace line of business.

A sample partially-completed Compliance Plan and Organizational Chart Cover Sheet looks like Figure 1A-2.

Figure 1A-2. Sample Compliance Plan and Organizational Chart Review Cover Sheet

QHP Issuer Compliance Plan and Organizational Chart REVIEW COVER SHEET			
<p><i>Issuers will be asked to submit a Compliance Plan and Organizational Chart as part of the application process for certification of qualified health plan(s). The criteria listed below contain minimum requirements for this review. Compliance Plans will be reviewed based on this criteria. Issuers should respond to the evaluation criteria and, where applicable, state the page number where language supporting the response can be found. This initial evaluation and review cover sheet will be used to evaluate the adequacy of the Compliance Plan and Organizational Chart and will assist in the ongoing monitoring of issuer compliance.</i></p> <p><i>Certification of a health plan does not prevent CMS from identifying or addressing weaknesses in the Compliance Plan and/or the Organizational Chart submitted by an issuer as part of its application at a later date.</i></p>			
Evaluation Criteria	Yes	No	Page Number
Compliance Plan and Organizational Chart Submissions			
Applicant uploaded a copy of its Compliance Plan.	<input checked="" type="radio"/>	<input type="radio"/>	N/A
Applicant uploaded a copy of the Organizational Chart.	<input checked="" type="radio"/>	<input type="radio"/>	N/A
Compliance Plan Contents			
A. Written policies and procedures			
1. Does the Compliance Plan include a statement that articulates the issuer's commitment to comply with all applicable federal and state rules, regulations, and standards?	<input checked="" type="radio"/>	<input type="radio"/>	1
2. Does the Compliance Plan include written standards of conduct for employees?	<input checked="" type="radio"/>	<input type="radio"/>	2-3
3. Does the Compliance Plan provide guidance for employees, contractors, subcontractors, or other applicable entities on the process for dealing with potential compliance issues?	<input checked="" type="radio"/>	<input type="radio"/>	4-5
4. Does the Compliance Plan describe the methods, process, and procedures used to implement the Compliance Program?	<input checked="" type="radio"/>	<input type="radio"/>	6-10
Page 1	QHP Issuer Compliance Plan and Organizational Chart Cover Sheet January 3, 2017		
CLOSE HOLD – DO NOT SHARE			
<small>INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.</small>			

Section 1B: State Licensure

1. Introduction

In the State Licensure section, issuers must indicate their licensure status and provide documentation that shows they satisfy licensure requirements for the applicable QHP markets, service areas, and products. To verify the licensure information, issuers must upload a copy of their state license, certificate of authority (COA), certificate of compliance, or an equivalent form or document for each state in which they seek QHP certification. An issuer may still apply for certification if it has not yet obtained a license or COA from the state Department of Insurance, but it must submit evidence of licensure during the QHP Application resubmission window. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, issuers need one of the following:

1. State license
2. COA
3. Certificate of compliance, which is included as part of the Uniform Certificate of Authority Application used to apply for a license or COA; and
4. A form or document equivalent to one of the above.

3. Quick Reference

Key Changes for 2018

- ◆ No changes for the 2018 QHP Application

Tips for the Licensure Section

- ◆ Issuers must provide licensure documentation for all products and service areas in which it intends to offer a QHP. This requirement applies to all licensed issuers, including any affiliated or other issuers underwriting the dental benefits that the QHP proposes to offer.
- ◆ Issuers must submit one form of licensure documentation (state license, COA, certificate of compliance, or the equivalent).
- ◆ If the issuer is not yet licensed and therefore unable to provide licensure documentation during the initial application submission, the issuer must submit evidence of licensure during the QHP Application resubmission window.
- ◆ Save documents using the following naming convention: [HIOS Issuer ID]_[Title of Document], for example, "12345_StateLicense.doc" or "12345_COA.doc" or "12345_CertificateofCompliance.doc."

4. Detailed Section Instructions

<i>Licensure Question</i>	<i>Steps</i>
<p>Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document authorizing it to offer every product type in every service area that it is currently applying for in the identified state?</p>	<p>Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the applicant is licensed for every product type and every service area for which it is applying. If Yes is selected, supporting documentation is required. Upload proof of licensure in the State Licensure Module and select the applicable document type (i.e., “State License,” “Certificates of Authority,” or “Description of Outstanding Licensure”). ◆ No—if the applicant is <u>not</u> licensed for every product type and every service area for which it is applying. If No is selected, proceed to next step.
<p>Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document for some but not all products, or some but not all service areas for which the applicant is currently applying in this QHP Application?</p>	<p>Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the applicant is licensed for some but not all product types or service areas for which it is applying. If Yes is selected, supporting documentation is required. Upload proof of licensure in the State Licensure Module and select the applicable document type (i.e., “State License,” “Certificates of Authority,” or “Description of Outstanding Licensure”). ◆ No—if the applicant is <u>not</u> licensed for any of the product types or service areas for which it is applying. If No is selected, enter the estimated date of licensure: ◆ The estimated date must be no later than 90 days before Open Enrollment. ◆ Issuers must be licensed to become certified.

Section 1C: Good Standing

1. Introduction

In the Good Standing section, an issuer must demonstrate compliance with all applicable state solvency and regulatory requirements. An issuer must be licensed in the state for which it is applying to satisfy the good standing standard. If an issuer does not comply with the good standing standard, it must complete the appropriate supporting documentation. These instructions apply to QHP and SADP issuers.

2. Data Requirements

If an issuer does not comply with the good standing standard, it needs to provide the following information:

1. If applicable, a description of how the issuer will comply with state solvency requirements and
2. If applicable, a description of how the issuer will respond to corrective actions.

3. Quick Reference

Key Changes for 2018
◆ No changes for the 2018 QHP Application

Tips for the Good Standing Section
<ul style="list-style-type: none"> ◆ If the issuer does not comply with the state solvency requirements or the issuer is under corrective action related to financial review, it must complete supporting documentation and provide a justification. ◆ Save documents using the following naming convention: [HIOS Issuer ID]_[Title of Document], for example, "12345_GoodStanding.doc."

4. Detailed Section Instructions

Good Standing Questions	Steps
1. Is the applicant seeking QHP certification for this state <u>currently out of compliance</u> with any applicable state solvency requirements for the calendar year in which it is applying to offer QHPs?	Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the applicant does <u>not</u> comply with state solvency requirements. If Yes is selected, supporting documentation and a justification are needed. Upload the supporting documentation in the Good Standing Module and select "Solvency Compliance" as the document type. ◆ No—if the applicant <u>complies</u> with state solvency requirements. If No is selected, proceed to the next step.
2. Is the applicant <u>currently under any corrective action</u> related to financial review?	Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the applicant <u>is</u> under corrective action related to financial review. If Yes is selected, supporting documentation and a justification are needed. Upload the supporting documentation in the Good Standing Module and select "Corrective Action" as the document type. ◆ No—if the applicant is <u>not</u> under corrective action related to financial review. If No is selected, proceed to the next section of the application.

Issuers that do not comply with the good standing standard must submit supporting documentation and a justification.

Good Standing Supporting Document

If the response to question 1 is **Yes** (the issuer does not comply with state solvency standards), the issuer must upload a description of how it intends to comply and provide a justification for noncompliance.

- ◆ The description should include the following:
 - List of solvency requirements with which the issuer currently does not comply
 - Detailed explanation of the plan to comply
 - Time frame for complying.

The justification should explain the conditions that caused the issuer to become financially insolvent (such as insufficient premium income or catastrophic medical expenses).

If the response to question 2 is **Yes** (the issuer is under corrective action), the issuer must upload a description of how it intends to respond to corrective actions and provide a justification.

- ◆ The description should include the following:
 - List of corrective actions issued
 - Detailed explanation of the plan to respond to corrective actions
 - Time frame for implementing the corrective actions plan.

The justification should explain how a corrective action plan or equivalent document will address the issues identified by the state.

Section 1D: Accreditation

1. Introduction

In the accreditation section, an issuer will need to enter information to satisfy the accreditation QHP certification requirement. Issuers can enter information for an accredited product in the Commercial, Medicaid, or Marketplace markets. These instructions apply only to FFM QHP issuers filing through HIOS.

States performing plan management functions and SBM-FP issuers do not need to submit the Accreditation Templates if they are submitting a QHP Application through SERFF, and the state does not require the templates. Instead, the issuer should comply with the requirements for accreditation data collection specified by its state.

2. Data Requirements

To complete this section, an issuer needs the following information:

1. For Accreditation Association for Ambulatory Health Care (AAAHC) accreditations
 - a. HIOS Issuer ID;
 - b. AAAHC organization identification number for existing AAAHC-accredited health plans, if applicable;
 - c. Current accreditation market type, status, and expiration date for the issuer's AAAHC-accredited products (found on the accreditation certificate); and
 - d. AAAHC accreditation certificates for existing accredited health plans in the state in which the issuer is applying to offer coverage, if applicable.
2. For National Committee for Quality Assurance (NCQA) accreditations
 - a. HIOS Issuer ID;
 - b. Product ID, which is the issuer's HIOS Product ID;
 - c. NCQA organization ID (Org ID) and Submission ID (Sub ID) for existing NCQA-accredited health plans, if applicable;
 - d. Current accreditation market type, status, and expiration date for the issuer's NCQA-accredited products (found on the accreditation certificate); and
 - e. NCQA accreditation certificates or a copy of the issuer's NCQA Interactive Survey System (ISS) results pages for each existing accredited health plan in the state in which the issuer is applying to offer coverage, if applicable.
3. For URAC accreditations
 - a. HIOS Issuer ID;
 - b. URAC certificate number (referred to as the "application number" on the template) for existing URAC-accredited health plans, if applicable;
 - c. Current accreditation market type, status, and expiration date for the URAC-accredited products (found on the accreditation certificate); and
 - d. URAC accreditation certificates for each existing accredited health plan in the state in which the issuer is applying to offer coverage, if applicable.
4. QIS

3. Quick Reference

Key Changes for 2018

- ◆ An issuer entering its fifth consecutive year of participation in the Marketplace is not required to submit accreditation certificate(s) with its application.

Tips for the Accreditation Section

- ◆ If an issuer is entering its initial year of QHP certification, it must schedule (or plan to schedule) a review with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). An issuer is not required to be accredited in its initial year of QHP certification.
- ◆ Any information provided on accredited products must be for the same legal entity in the same state that submits the QHP Application.
- ◆ If an issuer is entering its fourth consecutive year of QHP participation, it must be accredited in the Marketplace market and with one of the following statuses:
 - AAAHC: Accredited
 - NCQA: Excellent, Commendable, Accredited, or Provisional
 - URAC: Full or Conditional.
- ◆ If an issuer is accredited by AAAHC, it must e-mail its accreditation data to CMS_FEPS@cms.hhs.gov.
- ◆ An issuer must provide its accrediting entities with the issuer legal name and HIOS Issuer ID used in its QHP Application to ensure the correct name is used on its accreditation certificates.
- ◆ Excel template file names must be all lowercase and cannot contain spaces. For example, “accreditation_data” is a valid template file name, but “Accreditation_data” or “accreditation data” is not a valid template file name.
- ◆ Use the following naming convention for the accreditation certificate: [HIOS Issuer ID]_[Name of Accrediting entity], for example, “12345_NCQA.pdf”.

4. Detailed Section Instructions

Accreditation Questions	Steps
Does the applicant currently have any Commercial, Medicaid, or Marketplace health plans in this state, <i>[state of issuer identified]</i> , accredited by a HHS recognized accrediting entity?	Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the issuer has existing health plan accreditations on any products in the Marketplace, Commercial, or Medicaid market from NCQA or URAC. Dual issuers with an accredited medical plan should also select Yes. Proceed to the next step. ◆ No—if the issuer is accredited by AAAHC, is offering SADPs, or is not currently accredited by NCQA or URAC.
Issuers who respond Yes to the above question must then select the accrediting entity.	Choose from the following options: <ul style="list-style-type: none"> ◆ NCQA—if the issuer is accredited by NCQA. ◆ URAC—if the issuer is accredited by URAC. ◆ NCQA & URAC—if the issuer is accredited by both NCQA and URAC.

After responding to the above question, issuers will be asked to complete the Terms and Conditions attestation regardless of whether they are accredited.

Accreditation Attestations	Steps
Terms and Conditions	Check the “I attest to the terms and conditions” box.

The following steps are taken to complete the AAAHC Template.

AAAHC Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
AAAHC Org ID	Enter the AAAHC organization identification number printed on the Medicaid market accreditation certificate.
Market Type	Use the drop-down menu to select the appropriate market.
Accreditation Status	Use the drop-down menu to select the appropriate status.
Expiration Date	Enter the accreditation expiration date using the mm/dd/yyyy format. The template only accepts an expiration date in the future.

A sample completed AAAHC Template looks like Figure 1D-1.

Figure 1D-1. Sample AAAHC Template

	A	B	C	D	E
1	AAAHC Template v1.0	<i>All fields with an asterisk (*) are required. To validate the template, use the Validate button or Ctrl + Shift + V.</i>			
2	<input type="button" value="Validate"/>	<i>Please reference Chapter 5 of the QHP Instructions for instructions on completing this template</i>			
3					
4					
5					
6					
7	HIOS Issuer ID*	12345			
8	AAAHC Org ID*	Market Type*	Accreditation Status*	Expiration Date*	
9	Required: Enter the 3 to 6 digit AAAHC Org ID	Required: Select the Market Type from list	Required: Select the Accreditation Status from list	Required: Enter a date after 05/27/2014 in mm/dd/yyyy format	
10		123456 Exchange	Accredited	10/10/2015	
11		123456 Commercial	Accredited	12/10/2016	
12		123456 Medicaid	Accredited	05/07/2015	

The following steps are taken to complete the NCQA Template.

NCQA Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Market Type	Use the drop-down menu to select the appropriate market.
NCQA Sub ID	Enter the applicable sub ID. If the issuer has an NCQA accreditation status of Accredited on an identified product, but the issuer's organization has not yet submitted Healthcare Effectiveness Data and Information Set (HEDIS) or Consumer Assessment of Healthcare Providers and Systems (CAHPS) data for this product and does not have an NCQA Sub ID, enter 99999 in the Sub ID field for this product.
Product Type	Use the drop-down menu to select the appropriate product type.
Product ID	Using the following format, enter the product ID: five-digit HIOS Issuer ID + two-letter state abbreviation + three digits (e.g., 12345MD001). If the issuer has multiple product IDs per product type, it needs to use only any one product ID. The market types for the issuer's Product ID and its accredited product do not need to match. If the issuer does not have a Product ID that matches the accredited product type, fill in any valid Product ID associated with the HIOS Issuer ID.

NCQA Template	Steps
Accreditation Status	Use the drop-down menu to select the appropriate accreditation status. The tips below will help avoid validation errors in the template: <ul style="list-style-type: none"> ◆ Interim must be selected for Exchange/Marketplace products even if the issuer's certificate status is Accredited. ◆ Accredited must be selected if the issuer's certificate status is New Health Plan. ◆ Accredited must be selected if the issuer's certificate status is Provisional, unless the accreditation is for the Exchange/Marketplace market, in which case the issuer must select Interim.
Expiration Date	Enter the accreditation expiration date using the mm/dd/yyyy format. The template only accepts an expiration date in the future.

A sample completed NCQA Template looks like Figure 1D-2.

Figure 1D-2. Sample NCQA Template

A	B	C	D	E	F	G
1	2018 NCQA Template v7.0					
2	All fields with an asterisk (*) are required. To validate the template, use the Validate button or Ctrl + Shift + I. To finalize the template, use the Finalize button or Ctrl + Shift + F.					
3	The information for the accredited products must be for the same legal entity as is submitting the QHP application.					
4	Please follow the instructions provided in the Accreditation Chapter (Chapter 5) of the QHP Application Instructions Manual closely and carefully.					
5	The Department of Health and Human Services (HHS) will verify the information that you have provided about your existing accreditation with NCQA, URAC, or both.					
6	Only data that can be verified will be displayed on the website.					
7	It is only necessary to enter one accreditation entry per product/market type, using the product with the largest number of covered lives.					
8	HIOS Issuer ID*	12345				
9	NCQA Org ID*	Market Type*	NCQA Sub ID	Product Type*	Product ID*	Accreditation Status*
10	Required: Enter the 2-5-digit NCQA Org ID number	Required: Select the Market Type from list	Required if Market is NOT Exchange: Enter the 2-5-digit NCQA Sub ID number	Required: Select the Product Type from list	Required: Enter the 10-character Product ID	Required: Select the Accreditation Status from list
11	234 Commercial		100 PPO Only	12345MD001	Excellent	1/10/2018
12	9876 Exchange		300 POS Only	12345MD003	Interim	5/12/2018
13	45678 Medicaid		300 HMO Only	12345MD005	Accredited	10/10/2018

The following steps are taken to complete the URAC Template.

URAC Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
URAC Application Number	Enter the URAC certificate number printed on the accreditation certificate.
Market Type	Use the drop-down menu to select the appropriate market.
Accreditation Status	Use the drop-down menu to select the appropriate accreditation status.
Expiration Date	Enter the accreditation expiration date using the mm/dd/yyyy format. The template only accepts an expiration date in the future.

A sample completed URAC Template looks like Figure 1D-3.

Figure 1D-3. Sample URAC Template

	A	B	C	D
1	2018 URAC Template v7.0	<i>All fields with an asterisk (*) are required. To validate the template, use the Validate button.</i>		
2	<input type="button" value="Validate"/>	<i>The information for the accredited products must be for the same legal entity as is submitted.</i>		
3		<i>Please follow the instructions provided in the Accreditation Chapter (Chapter 5) of the QHP Application System.</i>		
4	<input type="button" value="Finalize"/>	<i>The Department of Health and Human Services (HHS) will verify the information that you provide. Only data that can be verified will be displayed on the website.</i>		
5				
6				
7	HIOS Issuer ID*	56789		
8	URAC Application Number* Required: Enter the 9-10 alphanumeric URAC Application Number	Market Type* Required: Select the Market Type from list	Accreditation Status* Required: Select the Accreditation Status from list	Expiration Date* Required: Enter a future date in mm/dd/yyyy format
9				
10	abc133000	Exchange	Full	10/10/2018
11	abc133001	Exchange	Provisional	12/30/2018
12	abc133002	Commercial	Conditional	01/22/2019

Once the Accreditation Template(s) is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML file of the template that the issuer needs to upload in the Accreditation section of the Issuer Module in the QHP Application System.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel.XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the Accreditation section of the Issuer Module in the QHP Application System. Refer to the Issuer Module User Guide for details on how to complete this.

Issuers must also upload copies of their accreditation certificate(s) into HIOS.

Accreditation Certificate	Steps
Scan Certificate	Scan each accreditation certificate (one per accredited market type). If an issuer is accredited by NCQA and does not have a copy of its accreditation certificate, use the NCQA ISS to get a copy of the survey results. Log into ISS, click on the Results tab, view the survey results, and print the results screen.
Name File	Use the following naming convention for the certificate: [HIOS Issuer ID]_[Name of Accrediting entity]. For example, "12345_NCQA.pdf."
Upload Certificate	Upload the saved file(s) in the Accreditation section of the Issuer Module in the QHP Application System. Refer to the Issuer Module User Guide for details on how to complete this.

Figure 1D-4 through Figure 1D-6 show sample accreditation certificates.

Figure 1D-4. Sample NCQA Accreditation Certificate



Figure 1D-5. Sample URAC Accreditation Certificate



Figure 1D-6. Sample AAAHC Accreditation Certificate



If an issuer is unable to locate the NCQA certificate, use the NCQA ISS to obtain a copy of the survey results. Log into ISS, click on the Results tab, view the survey results, and print the results screen. Figure 1D-7 and Figure 1D-8 show sample NCQA ISS survey results.

Figure 1D-7. Sample NCQA ISS Survey Results, page 1

How to View Results?

Step 1: **Login to ISS**

Step 2: **Click Results Tab to View**



2013 Standards and Guidelines for the Accreditation of Health Plans

Welcome to the Interactive Survey System!

The information in the following sections includes:

- the complete Standards
- information about how your organization will be evaluated against the Standards
- policies and procedures

We designed the system to facilitate understanding of our Standards and the evaluation process. The "Help and Instructions" section above directs users to assistance.

Policies and Procedures - This section provides an overview of the survey option you have selected; it describes the goals and principles that guide our approach to evaluation, and provides a high-level summary of areas addressed by the Standards.

The Policies and Procedures describe:

- eligibility criteria; evaluation options; the interactive survey process
- the structure of the Standards and Guidelines and the Survey Tool
- how we report survey results; and obligations of organizations and individuals undergoing a survey.

Standards and Guidelines - This section allows you to open or download printable versions of publications.

Survey Tool - This section includes the Standards used for evaluation. Standards are organized into categories or functions. Included are:

- the Standards
- the elements that specify how Standards are scored and evaluated
- specific scoring rules for each element
- data sources needed to support scoring
- the scope of review for each element and
- additional explanation and examples.

The Survey Tool allows you to evaluate yourself just as we will evaluate you, but at your own pace. You may score yourself, attach the necessary documentation and make comments. Following your readiness evaluation, if you elect to apply for and undergo a survey you submit the Survey Tool and begin the process. During the survey, your assessment and documentation will be reviewed to determine your performance against the Standards.

Organization Background - This section allows you to provide background, historical and other contextual information to us to assist during a survey. This information is not evaluated or scored but is used to help us understand your organization.

Results - As you complete the Survey Tool this section provides summarized and detailed results. Results are final only

Figure 1D-8. Sample NCQA ISS Survey Results, page 2

Step 3: View Results Page

2013 Standards and Guidelines for the Accreditation of Health Plans

Select an evaluation option for which to view results.

Name:

Evaluation Option: Interim Survey

Standards Year: 2013

Product Line/Product	Overall Score	Status	Valid Dates

*Reports and numeric results are not final and may not be made public until NCQA's Review Oversight Committee evaluates them. The organization may not represent that it has achieved any endorsement or approval, or that it is in compliance with any standards or is NCQA Accredited based on reports or numeric results from the readiness evaluation without a final decision as described in the Policies and Procedures.

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Section 1E: Essential Community Providers/Network Adequacy

1. Introduction

In the ECP/Network Adequacy section, issuers will need to demonstrate that they meet the requirements of having a network of contracted in-network providers to provide reasonable access to all covered services and a sufficient number and geographic distribution of ECPs, as well as collect provider data in each network associated with a QHP. These instructions apply to QHP and SADP issuers.

2. HIOS Interface

Issuers must respond to all attestations in the Issuer Module. The ECP/Network Adequacy section of the HIOS Issuer Module will consist of three questions; the last two questions are specifically for network adequacy (please refer to below—note the numbering corresponds to the HIOS screens):

Essential Community Providers

1. Applicant attests that it meets the General ECP Standard or the Alternate ECP Standard (as defined in the Annual Letter to Issuers):
 - a. In order to meet the General ECP Standard, the applicant has:
 - i. Contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;
 - ii. Offered contracts in good faith to all available Indian health care providers in the plan's service area for the respective QHP certification plan year; and
 - iii. Offered contracts in good faith to at least one ECP in each ECP category in each county in the service area for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants).
 - b. In order to meet the Alternate ECP standard, the applicant has:
 - i. Contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network; and
 - ii. Offered all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise offered a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area (not applicable to SADP applicants).
 - c. **Yes.** (Answer **Yes** if the applicant meets the ECP requirements listed above.)
 - d. **No.** (Answer **No** if the applicant does not meet the ECP requirements listed above. Applicants answering **No** are required to submit a supplemental ECP response.)

Network Adequacy

2. Does the applicant attest to meeting all the requirements established under 45 CFR 156.230, including maintaining a network that is sufficient in number and types of providers to ensure that all services will be accessible without unreasonable delay in accordance with 45 CFR 156.230(a)(2)? This includes providers that specialize in mental health and substance abuse services for all plans except SADPs.
 - a. **Yes.** (Answer **Yes** if the applicant attests to meeting all requirements established under 45 CFR 156.230, which includes maintaining a sufficient network.)
3. Are you required to submit an ECP/Network Adequacy Template?
 - a. **Yes.** (Answer **Yes** if the applicant is a SERFF issuer or a HIOS issuer who is not offering ONLY indemnity plan designs. All SERFF issuers must submit an ECP/Network Adequacy Template and

supporting documentation [including those issuers that are offering only indemnity plan designs]. Indemnity plan designs should upload “dummy” data as displayed in the table below.)

- b. **No.** (Answer **No** if the applicant is a HIOS issuer and is offering only indemnity plan designs.)

Indemnity Plan Dummy Data: Issuers should complete the **User Control** tab and populate the first row in the **Individual Providers** tab with the data in Table 1E-1. All other tabs should be blank.

Table 1E-1. Dummy Data Information

<i>Column</i>	<i>Data</i>
NPI:	Enter 1234567893
First Name of Provider:	Enter Abc
Last Name of Provider:	Enter Xyz
Physician/Non-Physician:	Select Physician
Specialty Type:	Select or enter 001 General Practice
Street Address:	Enter 123 Elm Street
City:	Choose a city in the state associated with the plan
State:	Choose the state associated with the plan
County:	Choose the county associated with the above-entered city
ZIP:	Enter 00000
Network:	Select one of the automatically created network IDs.

3. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID;
2. Issuer state;
3. Completed Network ID Template;
4. **New for this year:** This section is only required for issuers who are notified by email that they would need to provide this information. All other issuers do not need to populate the Network Adequacy sections of the template. A list of providers in each of the proposed networks, including providers outside the service area (such as in contiguous counties, even if they are across state lines). If a provider is in-network and enrollees can access that service include: provider name, National Provider Information (NPI), specialty and facility type, street address of location providing services, city, state, county, and ZIP code;
5. A list of ECPs in each of the proposed networks, including provider name, NPI, ECP category, street address of location providing services, city, state, county, zip code, number of contracted providers, and associated issuer network IDs;
6. An ECP Write-in Worksheet (as applicable);
7. Supplemental ECP Response—QHP (as applicable);
8. Supplemental ECP Response—SADP (as applicable); and
9. Access Plan with Cover Sheet (issuers who are required to submit Access Plans will be notified by email).

4. Quick Reference

Key Changes for 2018	
ECP Updates	
<ul style="list-style-type: none"> ◆ Issuers will provide hospital bed-count information as part of the ECP portion of their ECP/Network Adequacy Template. ◆ Issuers will be evaluated against a 20 percent ECP standard. 	
Network Adequacy Updates	
<ul style="list-style-type: none"> ◆ Except for Issuers in Network Breadth Pilot states, Issuers are not required to submit Network Adequacy data (Individual and Facility/Pharmacy) via the ECP/NA Template. Issuers in Network Breadth Pilot states will be required to provide Network Adequacy data via the ECP/NA Template, and will be notified directly by email. ◆ Network Adequacy Justifications will not be requested by CCIIO. ◆ Some QHP and SADP Issuers are required to submit an Access Plan with Cover Sheet. Access Plans must be uploaded as Supporting Documents (see the Supporting Documents table at the end of this section for details). Issuers who are required to submit an access plan will be notified directly by email. 	

Tips for the ECP/Network Adequacy Section	
<ul style="list-style-type: none"> ◆ Issuers must complete the <i>Issuer Information</i> section on the User Control tab before creating and entering the rest of their data into the other tabs. ◆ Issuers <u>should not</u> change the file names on their ECP/Network Adequacy files after finalizing the template. This file-naming convention allows CMS to easily identify an issuer's ECP/Network Adequacy Template. Changing the file name could cause the issuer to receive a correction notice. ◆ Complete the Network ID Template before completing the ECP/Network Adequacy Template. ◆ The PY2018 ECP/Network Adequacy Template includes the ability to delete rows. 	

5. Detailed Section Instructions

<i>User Control Tab</i>	<i>Steps</i>
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Source System	Select the name of the system used to submit the QHP Application. <ul style="list-style-type: none"> ◆ HIOS—if the user is an FFM issuer. ◆ SERFF—if the user is an issuer in a state performing plan management functions in an FFM (State Partnership Marketplace).
State	Select the state in which the issuer is applying to offer QHPs using the drop-down menu.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the user is an alternate ECP standard issuer as described under 45 CFR 156.235(b). ◆ No—if the user is a general ECP standard issuer.

Select ECPs Tab	Steps
Filter ECPs	<p>The columns on the Select ECPs tab can be filtered to make selecting ECPs easier. For example, filter the <i>Site State</i> column to show only ECPs available in the issuer's state. SADP issuers may want to filter on Column F, <i>ECP Category</i>, for any provider with "Dental Providers" listed to display only dental providers.</p>
Add ECPs	<p>Double-click anywhere on the row for the ECPs the user wants to add to the ECP tabs. Once selected, the row will be highlighted in blue and "add" will appear in the <i>Add ECP?</i> column. Continue selecting the ECPs until all contracted ECPs from the ECP list are selected.</p> <ul style="list-style-type: none"> ◆ To unselect an ECP, double-click on the selected row. The blue highlighting will be removed, and the ECP will not be added to the ECP tabs. ◆ To clear ALL selected ECPs, click the Clear All button at the top of the tab, and all highlighted ECPs will be deselected and will not be added to the ECP tabs. ◆ To show only those ECPs that have been selected, click the Show Selected ECPs button at the top of the tab and all highlighted ECPs will be displayed. To undo this action and show all ECPs, click the Show All ECPs button.
Insert ECPs	<p>Click the Insert Selected ECPs button. The selected ECPs will be added to the Facility ECPs tab (providers with more than one FTE practitioner and inpatient hospital providers) or to the Individual ECPs tab (providers with one or fewer FTE practitioners) of the ECP/Network Adequacy Template. The template will not populate duplicate ECPs into the Facility ECPs or Individual ECPs tabs.</p> <ul style="list-style-type: none"> ◆ For each ECP facility that was selected and inserted from the Select ECPs tab, a record will be added to the Facility ECPs tab that includes the following: row number, NPI, facility name, provider name, street address, city, state, ZIP, county, and ECP category. Any field that is not populated from the Select ECPs tab must be completed by the issuer before the template is validated. ◆ For each individual ECP that was selected and inserted from the Select ECPs tab, a record will be added to the Individual ECPs tab that includes the following: row number, NPI, name of provider, specialty type, street address, city, state, ZIP, county, and ECP category.

A sample **Select ECPs** tab looks like Figure 1E-2.

Figure 1E-2. Sample ECPs Tab

Add ECP?	Row Number	Site Name	Organization Name	National Provider Identifier	ECP Category (General ECP Standard Issuers Only)	Number of Medical FTEs or Bed Count	Number of Decert FTEs	Site Street Address 1	Site Street Address 2	Site City	Site State	Site Zip Code	
	201800002	Adak Medical Clinic	EASTERN ALEUTIAN TRIBES	1285796094	Community Mental Health Centers, Dent.	8	1	2105 Main St	PO Box 2105	Adak	AK	99546-2105	
ADD	201800003	Ahtook Village Clinic	KODIAK AREA NATIVE ASSON	1205883907	Dental Providers, Federally Qualified Hea	1	0	1 3rd Ave		Ahtook	AK	99615	
	201800004	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1	0	1 Main St	PO Box 51089	Alaskaket	AK	99551-0209	
	201800005	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1	0	148 Post Rd	PO Box 216	Alaskaket	AK	99552	
ADD	201800006	ANESIA KUDRIN MEMORIAL C	Eastern Aleutian Tribes, Inc.	1558423392	Community Mental Health Centers, Dent.	1	0	1 113 Main St	PO Box 113	Aktutan	AK	99553-0113	
	201800007	Yukon-Kuskokwim Health Corp	YUKON-KUSKOKWIM HEALTH	1447477815	Indian Health Service, Other ECP Provide	1	0	Anderson Street Clinic Drive	PO Box 288	Alakanuk	AK	99554-0288	
	201800008	ALLAKAKET HEALTH CLINIC	Tanana Chiefs Conference (DEH)	1821201278	Community Mental Health Centers, Dent.	0.2	0.02	Koyukuk River Junction		Allakaket	AK	99720	
ADD	201800009	SVT Health & Wellness	SELDOVIA VILLAGE TRIBE	1336178847	Federally Qualified Health Centers	1	0	34361 Old Sterling Hwy		Anchor Point	AK	99556-9500	
	201800010	Quyana Club House	Southcentral Foundation	1144274989	Other ECP Providers, Tribal Health Progr	0.9	0	0 225 Eagle St		Anchorage	AK	99501-2626	
ADD	201800011	Pediatric Cardiology of Alaska	Pediatric Cardiology of Alaska	1582829551	Other ECP Providers	2	0	3341 Piper St	Suite 1345	Anchorage	AK	99508-4694	
	201800012	Bleeding Disorder Center of Alai	Providence Medical Group	1093946278	Hemophilia Treatment Centers	5	0	3951 Piper St	Suite U120	Anchorage	AK	99502	
ADD	201800013	The Pathway Home	Southcentral Foundation	1639102882	Inpatient Hospitals (other than children's)	30	0	4000 San Ernesto Ave		Anchorage	AK	99508-2074	
	201800014	Anchorage Health Center	Planned Parenthood of the Grea	1083700686	Family Planning Providers, Sexually Tran	2	0	4001 Lake Otis Pkwy	Suite 101	Anchorage	AK	99508-5200	
	201800015	Dena A Coy Residential	Southcentral Foundation	1194678559	Inpatient Hospitals (other than children's)	14	0	4130 San Ernesto Ave		Anchorage	AK	99508-2075	
	201800016	Alaska Native Medical Center - S	Southcentral Foundation	1437189339	Other ECP Providers, Tribal Health Progr	136.5	0	4315 Diplomacy Dr		Anchorage	AK	99508-5926	
ADD	201800017	Alaska Native Medical Center	Alaska Native Tribal Health Con	1437368891	Dental Providers, Family Planning Provid	1	0	14 4315 Diplomacy Dr		Anchorage	AK	99508-5926	
	201800018	Alaska Native Medical Center	Alaska Native Tribal Health Con	1437368891	Dental Providers, Inpatient Hospitals	167	0	4315 Diplomacy Dr		Anchorage	AK	99508-5926	
	201800019	SCF ANMC CLINIC	SOUTHCENTRAL FOUNDATIO	1861533408	Dental Providers	0	0	14315 Diplomacy Dr		Dental Clinic	Anchorage	AK	99508-5926
	201800020	Anchorage Native Primary Care	Southcentral Foundation	1124064894	Community Mental Health Centers, Triba	11	0	4320 Diplomacy Dr		Anchorage	AK	99508-5925	
	201800021	SCF FIREWEED DENTAL CLIN	SOUTHCENTRAL FOUNDATIO	1861533408	Dental Providers	0	0	14341 Tudor Centre Dr		Fireweed Dental	Anchorage	AK	99508-5904
	201800022	Behavioral Health Fireweed	Southcentral Foundation	1932159076	Community Mental Health Centers, Triba	1.7	0	4341 Tudor Centre Dr		Anchorage	AK	99508-5904	
	201800023	Anchorage Neighborhood Health	ANCHORAGE NEIGHBORHOOD	1669475156	Dental Providers, Family Planning Provid	15	3.5	4951 Business Park Blvd		Anchorage	AK	99503-7174	
	201800024	Clinical Services - Department of	Municipality of Anchorage	1184979606	Family Planning Providers, Sexually Tran	3	0	825 L St	Suite No. 102	Anchorage	AK	99501-3337	
	201800025	SCARHO Jessie Norma Jim	SouthEast Alaska Regional Hea	1215893945	Federally Qualified Health Centers, Indar	2	0	725 Ratay Rd		Anchorage	AK	99520	
	201800026	ANAK SUB-REGIONAL CLINIC	YUKON-KUSKOKWIM HEALTH	1699857658	Federally Qualified Health Centers	2	0	269 Morgans Rd	PO Box 269	Anak	AK	99557-0269	
	201800027	YUKON-KUSKOKWIM HEALTH YUKON-KUSKOKWIM HEALTH	1447477815	Indian Health Service, Other ECP Provide	1	0	Charlie Wulf Road #89	PO Box 89	Anvik	AK	99558-0089		
	201800028	ARCTIC VILLAGE HEALTH CLIN	COUNCIL OF ATHABASCAN TI	1578753067	Federally Qualified Health Centers, Indiar	1	0	100 Main St		Arctic Village	AK	99722	
	201800029	APIAI Atka Village Clinic	Aleutian Pribilof Islands Associ	1093939233	Federally Qualified Health Centers, Indiar	1	0	900 A Health Ln		Atka	AK	99547	
	201800030	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1447477815	Indian Health Service, Other ECP Provide	1	0	101 Boardwalk Way	PO Box 6588	Atmautluak	AK	99559-6588	
	201800031	Samuel Simmonds Memorial Hc	Arctic Slope Native Association	1305933643	Dental Providers, Outpatient Hospital Clr	22	0	7000 Uluu St		Barrow	AK	99723	
	201800032	Samuel Simmonds Memorial Hc	Arctic Slope Native Association	1305933643	Inpatient Hospitals (other than children's)	10	0	7000 Uluu St		Barrow	AK	99723	
	201800033	BEAVER HEALTH CLINIC	COUNCIL OF ATHABASCAN TI	1205027505	Federally Qualified Health Centers, Indiar	1	0	101 Main St		Beaver	AK	99724	
	201800034	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1821476599	Indian Health Service, Other ECP Provide	2	0	1260 A Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559-0528	
	201800035	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1194945170	Indian Health Service, Other ECP Provide	1	0	5016 Noel Putty Blvd.	PO Box 528	Bethel	AK	99559-0528	
	201800036	BETHEL FAMILY CLINIC	BETHEL FAMILY CLINIC	1124078019	Federally Qualified Health Centers	2.5	0	631 Main St		Bethel	AK	99559	
	201800037	Yukon-Kuskokwim Delta Region	Yukon-Kuskokwim Health Corp	1063567891	Indian Health Service, Other ECP Provide	167	0	700 Chief Eddie Hoffman Hwy	PO Box 528	Bethel	AK	99559-0528	
	201800038	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1305262726	Dental Providers	0	0	21 829 Chief Eddie Hoffman Hwy	Suite 184	Bethel	AK	99559	
	201800039	Yukon-Kuskokwim Health Corp	Yukon-Kuskokwim Health Corp	1345486232	Indian Health Service, Other ECP Provide	2	0	829 Chief Eddie Hoffman Hwy	Suite 150	Bethel	AK	99559	
	201800040	FRANK TOBIUK SR. HEALTH C	DENA NAHNA HENASH	1821201278	Community Mental Health Centers, Dent.	0.2	0.02	1 Battles Rd		Bettles	AK	99726	

To complete the information on the **Facility ECPs** tab, follow the steps in the table below.

Facility ECPs Tab	Steps
Facility Type	Select the appropriate facility type for each ECP. Issuers may select multiple facility types for each ECP, as applicable. If none of the facility type selections apply to the ECP, select 000 OTHER .
Network IDs	Select the network IDs for each ECP. Issuers may select multiple network IDs for each ECP, as applicable. Dual issuers must create separate network IDs for their medical and dental plans.
Number of Medical FTEs or Bed Count	Enter the number of medical full time enrollees (FTEs) that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Nurse Practitioner (NP). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. For inpatient hospitals in the network, enter the bed count associated with the contracted inpatient services. Note that the maximum allowable number of FTEs or beds is equal to the available FTEs or beds reported by the respective provider at each site location, as reflected in Column G (<i>Number of Medical FTEs or Bed Count</i>) of the Select ECPs tab.

Facility ECPs Tab	Steps
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS). Decimal values may be entered as appropriate. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location as reflected in Column H (<i>Number of Dental FTEs</i>) of the Select ECPs tab.

A sample completed **Facility ECPs** tab looks like Figure 1E-3.

Figure 1E-3. Sample Facility ECPs Tab

Remove ECP?	Row Number	National Provider Identifier (NPI)	Facility Name	Facility Type	Provider Name	ECP Category (General ECP Standard Issuers Only)	Street Address
	201805740	1578797494	Bates County Memorial Hospital	Freestanding Cancer Centers, Outpatient Hospital Clinics, 003 Urology, 101 Pediatrics - Routine/Primary Care	FAMILY CARE CLINIC ADRIAN	Rural Health Clinics	102 E Main St
	201805741	1225191752	CROSS TRAILS MEDICAL CENTER	000 OTHER	Cross Trails Medical Center	Dental Providers, Federally Qualified Health Centers	307 W Gabriel St
	201805758	1194945154	SOUTHEAST MISSOURI HEALTH NETWORK	000 OTHER	Bernie Family Medical and Dental Clinic	Dental Providers, Federally Qualified Health Centers	741 S Walnut St
	201805771	1922032549	JOHN FITZGIBBON MEMORIAL HOSPITAL, INC	000 OTHER	GRAND RIVER MEDICAL CLINIC	Rural Health Clinics	815 E Broadway St
	201805772	1174992374	The Health Care Coalition of Lafayette County	Freestanding Cancer Centers, Inpatient Hospitals (other than children's hospitals), 051 Speech Therapy, 054 Orthotics and Prosthetics, 056 Durable Medical Equipment	Live Well Community Health Center Buckner	Dental Providers, Federally Qualified Health Centers	324 S Hudson St
	201805777	1669606588	Bates County Memorial Hospital	033 Urology, 034 Vascular Surgery, 101 Pediatrics - Routine/Primary Care	Nursery Street Family Care Clinic	Rural Health Clinics	617 W Nursery St
	201805790	1104279186	SGOH ACQUISITION, INC.	042 Cardiac Catheterization Services, 043 Critical Care Services - Intensive Care Units (ICU), 044 Outpatient Dialysis	OCH JASPER COUNTY CLINIC-CARTHAGE CAMPUS	Rural Health Clinics	327 E Airport Dr
	201805791	1437251634	Pemiscot Memorial Health Systems	055 Home Health	DOCTOR'S CLINIC	Rural Health Clinics	106 W 12th St
	201805792	1841463551	Pemiscot Memorial Health Systems	Children's Hospitals (inpatient only)	BOOTHHEEL PRIMARY CARE CLINIC CARUTHERSVILLE	Rural Health Clinics	1502 Ward Ave
	201805802	1710075361	Golden Valley Memorial Healthcare	000 OTHER	Golden Valley Memorial Hospital	Inpatient Hospitals (other than children's hospitals)	1600 N 2nd St
	201805804	1245669266	Compass Health, Inc.	000 OTHER	Compass Health - Clinton Clinic	Dental Providers, Federally Qualified Health Centers	1800 Community
	201805805	1689646143	FAMILY HEALTH CENTER OF BOONE COUNTY	000 OTHER	FAMILY HEALTH CENTER OF BOONE COUNTY	Federally Qualified Health Centers	1001 W Worley St
	201805815	1225225675	Ferguson Medical Group	000 OTHER	Ferguson Medical Group-Dexter Clinic	Other ECP Providers, Rural Health Clinics	1516 W Business US
	201805820	1881608685	CEDAR COUNTY MEMORIAL HOSPITAL	000 OTHER	CCMH MEDICAL MALL CLINIC	Rural Health Clinics	1317 S State Highway
	201805822	1669575908	Big Springs Medical Association dba Missouri Highlands Health Care	000 OTHER	BIG SPRINGS MEDICAL ASSOCIATION, INC	Dental Providers, Federally Qualified Health Centers	110 S 2nd St
	201805841	1972050581	SGOH ACQUISITION, INC.	000 OTHER	OCH GOODMAN FAMILY CLINIC	Rural Health Clinics	125 E Main St
	201805850	1649697566	SOUTHEAST MISSOURI HEALTH NETWORK	Dental - General	Hayti Medical Center	Dental Providers, Federally Qualified Health Centers	223 S 3rd St

To complete the information on the **Individual ECPs** tab, follow the steps in the table below.

Individual ECPs Tab	Steps
Physician/Non-Physician	Indicate the type of provider. Choose from the following: <ul style="list-style-type: none"> ◆ Physician—if the provider is a physician practitioner. ◆ Non-Physician—if the provider is a non-physician practitioner.
Specialty Type (area of medicine)	Select the appropriate specialty type for each ECP. Issuers may select multiple specialty types for each ECP, as applicable. If none of the specialty type selections apply to the ECP, select 000 OTHER .
Network IDs	Select the network IDs for each ECP. Issuers may select multiple network IDs for each ECP, as applicable. Dual issuers must create separate network IDs for their medical and dental plans.

Individual ECPs Tab	Steps
Number of Medical FTEs or Bed Count	Enter the number of medical FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Nurse Practitioner (NP). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column G (<i>Number of Medical FTEs or Bed Count</i>) of the Select ECPs tab.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location as reflected in Column H (<i>Number of Dental FTEs</i>) of the Select ECPs tab.

A sample completed **Individual ECPs** tab looks like Figure 1E-4.

Figure 1E-4. Sample Individual ECPs Tab

Remove ECP?	Row Number	National Provider Identifier (NPI)	Name of Provider	Physician/Non-Physician	Specialty Type (area of medicine)	Provider Entry Name	ECP Category
	201805748	1760472922	Archie Medical Clinic	Physician	Dental - General	Cass Regional Medical Center dba Archie Medical Clinic	Rural Health Cl
	201805779	1386022002	Compass Health - Butler Medical and Behavioral Health	Physician	000 OTHER	Compass Health	Federally Quali-
	201805781	1053433920	Cainsville Medical Clinic	Physician	Dental - General	NORTHWEST HEALTH SERVICES, INC.	Federally Quali-
	201805789	1386095255	Access Family Care	Non-Physician	Dental - General	Access Family Care	Dental Provider
	201805818	1881730893	Northeast Family Health	Physician	Dental - General	NORTHEAST MISSOURI HEALTH COUNCIL, INC.	Federally Quali-
	201805842	1841312444	Hamilton Medical Clinic	Physician	Dental - General	NORTHWEST HEALTH SERVICES, INC.	Federally Quali-
	201805849	1649697566	Hayti Dental Clinic	Physician	Dental - General	SOUTHEAST MISSOURI HEALTH NETWORK	Dental Provider

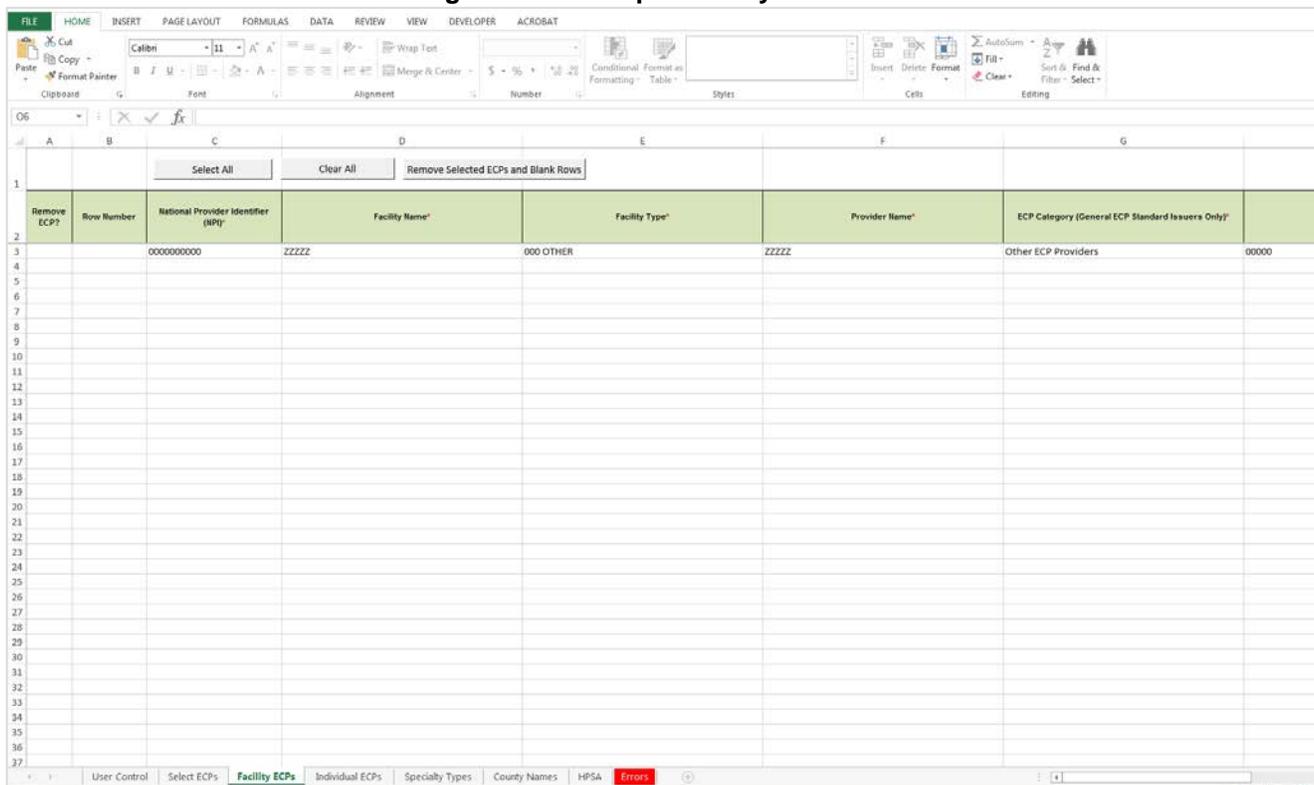
To remove ECPs from the **Facility ECPs** tab or the **Individual ECPs** tab, double-click the record to be deleted in the *Remove ECPs* column. The provider will be highlighted in blue. Click the **Remove Selected ECPs and Blank Rows** button to remove the ECP from the template.

Issuers proposing network(s) without ECPs: If an issuer is proposing network(s) without ECPs, enter the following values in the **Facility ECPs** tab in the ECP/Network Adequacy Template to indicate that there are no ECPs in the network(s) (the issuer must enter this information to proceed with the rest of the application).

<i>Facility ECPs Tab</i>	<i>Steps</i>
Row Number	Leave blank.
NPI	Enter 0000000000 .
Facility Name	Enter ZZZZZ .
Facility Type	Select 000 Other from the drop-down menu.
Provider Name	Enter ZZZZZ .
ECP Category	Select Other ECP Providers .
Street Address	Enter 00000 .
Street Address 2	Leave blank.
City	Enter ZZZZZ .
State	Select the state in which the service area is located from the drop-down menu.
County	Select a county from the drop-down menu.
ZIP Code	Select a ZIP code from the HPSA tab that is in the same state in which the service area is located.
Network IDs	Using the drop-down menu, select the network ID(s) associated with the network that does not have an available ECP.
Number of Medical FTEs or Bed Count	Enter 0 .
Number of Dental FTEs	Enter 0 .

A sample **Facility ECPs** tab for an issuer proposing a network without ECPs is shown in Figure 1E-5.

Figure 1E-5. Sample Facility ECPs Tab



Issuers planning to submit write-in ECPs should complete the ECP Write-in Worksheet. HHS will release the PY2018 Available ECP Write-in List and ECP Write-in Worksheet approximately 2 weeks prior to each QHP certification submission cycle. These documents will be made available at the CCIIO website (<https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy>). For general ECP standard issuers, only those providers who are listed on the PY 2018 Available ECP Write-in List will count as a qualified ECP write-in. Alternate ECP standard issuers must also use the ECP Write-in Worksheet to submit their employed or contracted ECPs located in HPSAs or low income zip codes, although CMS would not expect these practitioners to submit an ECP petition for inclusion on the PY 2018 Available ECP Write-in List since they are either employed by the issuer or practice within the issuer’s single contracted medical group.

To complete the information on the ECP Write-in Worksheet, follow the steps in the table below.

<i>ECP Write-in Worksheet</i>	<i>Steps</i>
HIOS ID	Enter the five-digit HIOS issuer ID.
Issuer State	Select the state in which the issuer is applying to offer QHPs.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the user is an alternate ECP standard issuer as described in 45 CFR 156.235(b). ◆ No—if the user is a general ECP standard issuer.

<i>ECP Write-in Worksheet</i>	<i>Steps</i>
Import Network IDs	Click on the Import Network IDs button to import data from the Network ID Template (please refer to Section 2A for detailed instructions on this template). The network IDs will automatically be imported to the write-in worksheet, and you will receive a message indicating that the network IDs were successfully added.
Approved Write-in Row Number	Enter the row number as it appears on the PY 2018 Available ECP Write-in List. For alternate standard issuers reporting ECPs that are not required to submit an ECP provider petition (i.e., providers who are employed by the issuer or practice within the issuer's single contracted medical group, the issuer should enter "NA" in this column.
Provider Name	Enter the provider name as it appears on the PY 2018 Available ECP Write-in List.
Site Name	Enter the site name as is appears on the PY 2018 Available ECP Write-in List.
Organization Name	Enter the organization name as it appears on the PY 2018 Available ECP Write-in List.
NPI	Enter the NPI as it appears on the PY 2018 Available ECP Write-in List.
ECP Category	Select the appropriate ECP Category for each ECP. Multiple ECP Categories for each ECP may be selected, as applicable. If none of the listed menu selections apply to the ECP, select Other ECP Providers .
Number of Medical FTEs or Bed Count	Enter the number of medical FTEs that are included in the identified provider networks for each ECP. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Nurse Practitioner (NP). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. For inpatient hospitals in the network, enter the bed count associated with the contracted inpatient services.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS). Decimal values may be entered as appropriate to reflect the contracted number of FTEs.
Site Street Address 1	Enter the site street address of the contracted provider as it appears on the PY 2018 Available ECP Write-in List.
Site Street Address 2	Enter additional street address information as it appears on the PY 2018 Available ECP Write-in List, as applicable.
Site City	Enter the city as it appears on the PY 2018 Available ECP Write-in List.
Site State	Select the site state from the drop-down list, as it appears on the PY 2018 Available ECP Write-in List.
Site Zip Code	Enter the site ZIP code as it appears on the PY 2018 Available ECP Write-in List. For alternate standard issuers, all ECPs must be in an HPSA or low-income ZIP code.
Site County	Select the site county from the drop-down list, as it appears on the PY 2018 Available ECP Write-in List.
Network ID(s)	Use the drop-down menu to select the network IDs for the networks to which the ECP belongs.
Validate the worksheet	Once all desired write-in ECPs are added to the worksheet, click the Validate button at the top of the worksheet. If there are errors identified, the worksheet will highlight the cells in red. Correct any errors and click Validate again. When all errors are corrected, a message will appear indicating that no validation errors were found.

<i>ECP Write-in Worksheet</i>	<i>Steps</i>
Export the worksheet	<p>Click the Export button at the top of the worksheet. A pop-up message will ask you to “Please select the folder where you would like the ECP write-in file to be saved.” Select the appropriate folder and hit “Select Folder” in the pop-up window. A .txt file containing the information from the ECP Write-in Worksheet is now saved at that location.</p> <p>When ready, submit the .txt file via the ECP/Network Adequacy Issuer Module application section within HIOS as a Supporting Document under the label “ECP Write-in Worksheet” supporting document.</p>

Network Adequacy: We will only be collecting individual and facility provider data from issuers participating in the network breadth pilot project for PY18. **DO NOT** click the Create Facility, Pharmacy, Non-MD/DO Tab button unless you have been notified by email to submit this data.

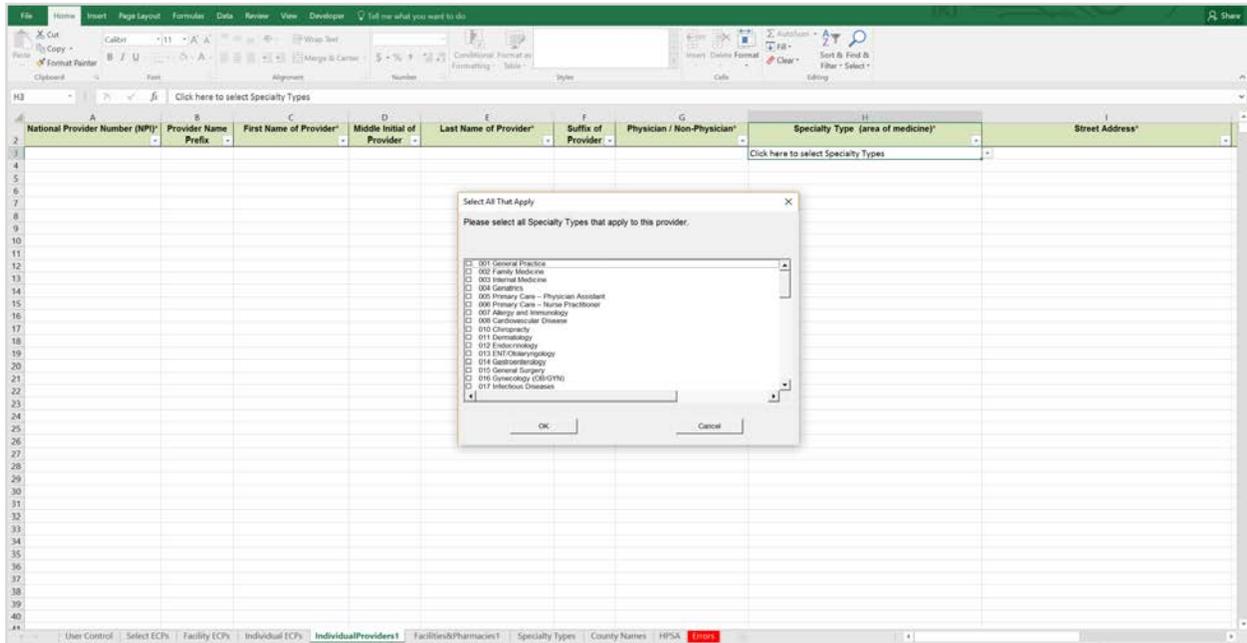
To complete the **Individual Providers** and **Facilities & Pharmacies** tabs, follow the steps in the tables below.

<i>Individual Provider Tab</i>	<i>Steps</i>
National Provider Identifier (NPI) (required)	Enter the provider’s 10-digit NPI in the <i>NPI</i> column. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if the NPI is unknown. If the issuer is unable to obtain the provider’s NPI for PY2018, enter 0000000000 (10 zeros) in the NPI field. Also, please ensure the NPI is active in the NPPES database.
Provider Name Prefix	Enter the prefix for the provider, such as “Dr.”
First Name of Provider	Enter the first name of the provider.
Middle Initial of Provider	Enter the middle initial of the provider.
Last Name of Provider	Enter the last name of the provider. If a provider has multiple office locations, each with a unique address, add a number to the provider name to distinguish each location, for example, Provider Name-001.
Suffix of Provider	Enter the provider suffix, as applicable, such as “Jr.” or “Sr.”
Physician/Non-Physician	Indicate the type of provider. Choose from the following options: <ul style="list-style-type: none"> ◆ Physician—if the provider is a physician practitioner. ◆ Non-Physician—if the provider is a non-physician practitioner.
Specialty Type (area of medicine)	<p>From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, all specialties should be selected in the same record.</p> <ul style="list-style-type: none"> ◆ The template does not allow direct entry into this field; however, issuers may copy and paste data into the template if the specialty type names appear exactly as they appear in the Specialty Types tab data, such as 001 General Practice. If pasted data does not exactly match the specialty type format used in the Individual Providers tab, errors will appear when the data is pasted. ◆ If the issuer would like to enter more than one specialty type for a provider, each specialty type must be separated by a comma and a space. ◆ If the specialty type(s) is not listed in the Specialty Types tab, please select specialty type 000 OTHER from the drop-down menu.
Street Address	Enter the street address of the provider. If the provider has multiple locations, enter each street address in a separate row. DO NOT use a P.O. Box in the address, as these cannot be geocoded for analysis. All providers with a P.O. Box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, if applicable.

Individual Provider Tab	Steps
City	Enter the city where the provider is located.
State	Enter the state where the provider is located, or select the state using the drop-down menu.
County	Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the County Names tab. Do not include the Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP	Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit or a nine-digit code, such as 00000 or 00000-0000.
Network ID	When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and Plans & Benefits Template. Dual-product issuers must create separate network IDs for their medical and dental plans. Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.

A sample **Individual Providers** tab looks like Figure 1E-6.

Figure 1E-6. Sample Individual Providers Tab



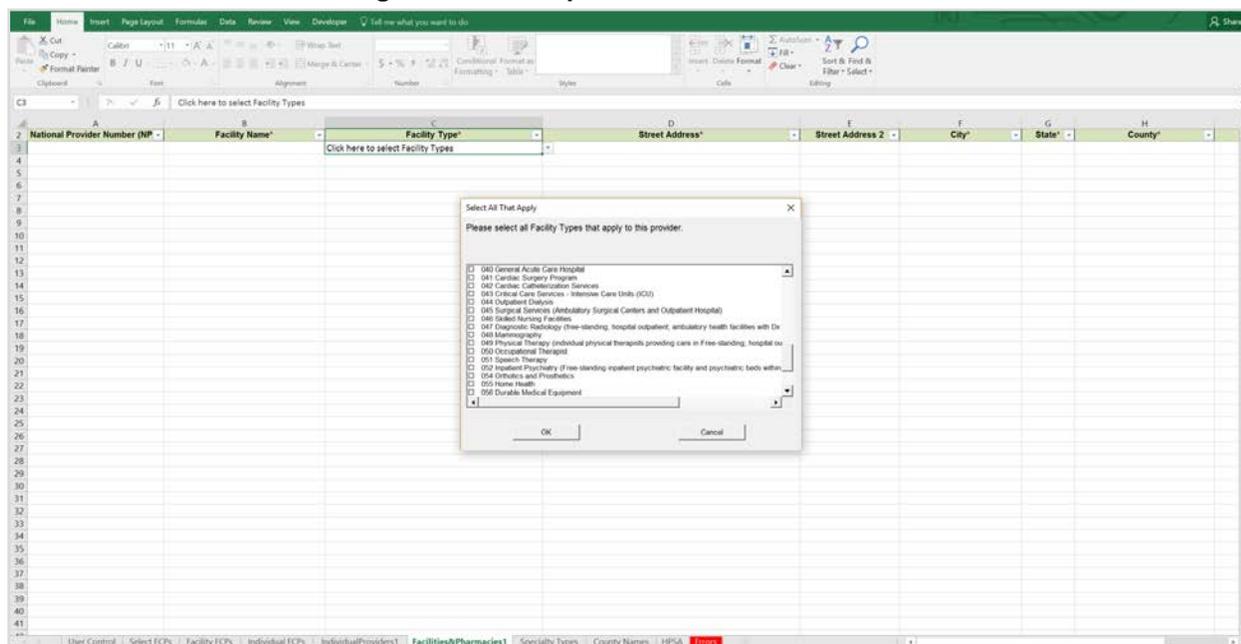
Individual Provider tabs can be removed from the template by using the **Delete** function, which is located in Column P of the **User Control** tab. Note that once a tab is deleted, it cannot be recovered, so it is recommended that the template be saved before tabs are deleted.

Facilities & Pharmacies Tab	Steps
National Provider Identifier (NPI)	Enter the provider's 10-digit NPI. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if it is unknown. If the issuer is unable to obtain the provider's NPI for PY2018, enter 0000000000 (10 zeros) in the NPI field. Also, please ensure that the NPI is active in the NPPES database.

Facilities & Pharmacies Tab	Steps
Facility Name	Enter the name of the facility or pharmacy.
Facility Type	<p>From the drop-down menu, select all facility types that apply to the facility location. If a facility has multiple facility types at the same address, then all facility types should be selected in the same record. The accepted facility types are listed on the Specialty Types tab of the template.</p> <ul style="list-style-type: none"> ◆ The template does not allow direct entry into this column; however, issuers may copy and paste data into the template if the facility type names appear exactly as they appear in the Specialty Types tab, such as 040 General Acute Care Hospital. If pasted data does not exactly match the facility type format used in the Facilities & Pharmacies tab, errors will appear when the data is pasted. ◆ If entering more than one facility type, each facility type must be separated by a comma and a space. ◆ If the facility type(s) is not listed in the Specialty Types tab, please select facility type 000 OTHER from the drop-down menu.
Street Address	Enter the street address of the provider. This is the address where the enrollee obtains services, and not the corporate location unless they are the same. If the provider has multiple locations, enter each street address in a separate row. DO NOT use a P.O. Box in the address, as it cannot be geocoded for analysis. All providers with a P.O. Box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, as applicable.
City	Enter the city where the provider is located.
State	Enter the state where the provider is located, or select the state using the drop-down menu.
County	Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the County Names tab. Do not include the FIPS code when entering the county name.
ZIP	Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit or a nine-digit code, such as 00000 or 00000-0000.
Network ID	When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and Plans & Benefits Template. Dual-product issuers must create separate network IDs for their medical and dental plans. Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.

A sample **Facilities & Pharmacies** tab looks like Figure 1E-7.

Figure 1E-7. Sample Facilities & Pharmacies Tab



Reference information is provided in the three tabs listed below:

- **Specialty Types** tab contains the specialty/facility and pharmacy types that can be added into the ECP/Network Adequacy Template.
- **County Names** tab contains the county names that are used and accepted in the ECP/Network Adequacy Template.
- **HPSA** tab contains the HPSA and low-income ZIP codes. The issuer can filter by ZIP code and by state.

The **Errors** tab displays any validation errors identified when a completed ECP/Network Adequacy Template is validated.

1. Column A—Tab: indicates the tab that produced the error.
2. Column B—Cell: indicates the cell location for the specific error and a hyperlink that allows the issuer to navigate to the exact cell in the correct tab.
3. Column C—Validation Error Message: describes the error.

Once the ECP/Network Adequacy Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the Validate Data button on the User Control tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Errors	If the template has any errors, they will appear on the Errors tab showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Create Documents	Click the Create Documents button on the User Control tab. This function will create a separate .XML file for each tab in the workbook. All of the separate files will be compressed into one zip file, which will need to be uploaded in the ECP/Network Adequacy section of the Issuer Module in the QHP Application System.

Template Validation	Steps
Save Template	Save the .XML files and template. CMS recommends that the issuer save the validated template on its computer as a standard Excel.XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved files in the ECP/Network Adequacy section of the Issuer Module in the QHP Application System. Refer to the Issuer Module User Guide for details on how to complete this.

Supporting Documents

General ECP Standard Issuers Supplemental ECP Response Form and Justification	<ul style="list-style-type: none"> ◆ An issuer needs to submit an ECP supplemental response form if <u>one of the following applies</u>: <ul style="list-style-type: none"> ▪ The issuer does not contract with at least 20 percent of the available ECPs in each applicable service area. ▪ The issuer does not offer a contract in good faith to all Indian health care providers in each plan's service area for the respective QHP certification plan year, applying the special terms and conditions required by federal law and regulations as referenced in the recommended model QHP Addendum for Indian Health Care Providers developed by HHS, available at https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy. ▪ The issuer does not offer a contract in good faith to at least one ECP in each available ECP category in each county in the service area for the respective QHP certification plan year. ◆ The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name. For example: 12345_ecpsupplementalresponse_20170601.
Alternate ECP Standard Issuers Supplemental ECP Response Form and Justification	<p>An issuer needs to submit an ECP supplemental response form if <u>one of the following applies</u>:</p> <ul style="list-style-type: none"> ◆ The issuer does not include in each plan network at least the equivalent of 20 percent of available ECPs in each plan service area, and these providers are located within HPSAs or ZIP codes in which 30 percent or more of the population falls below 200 percent of the federal poverty line (FPL). ◆ The issuer does not offer an integrated delivery system that provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise offer a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals (not applicable to SADP applicants). <p>The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name. For example: 12345_ecpsupplementalresponse_20170601.</p>
Cover Sheet and Access Plan	<p>QHPs and SADPs that need to submit access plans will be notified directly by email. These issuers will be required to submit a Cover Sheet and Access Plans that addresses the 11 areas below. The Cover Sheet must include page references to each of the 11 areas in the Access Plan.</p> <ol style="list-style-type: none"> 1. The health carrier's network, including how the use of telemedicine or tele health or other technology may be used to meet network access standards, if applicable; 2. The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable; 3. The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans; 4. The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select [and/or tier] providers;

Supporting Documents

5. The health carrier's efforts to address the needs of covered persons, including, but not limited to children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;
6. The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;
7. The health carrier's method of informing covered persons of the plan's covered services and features, including but not limited to:
 - a. The plan's grievance and appeals procedures;
 - b. Its process for choosing and changing providers;
 - c. Its process for updating its provider directories for each of its network plans;
 - d. A statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
 - e. Its procedures for covering and approving emergency, urgent and specialty care, if applicable;
8. The health carrier's system for ensuring the coordination and continuity of care:
 - a. For covered persons referred to specialty physicians; and
 - b. For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;
9. The health carrier's process for enabling covered persons to change primary care professionals, if applicable;
10. The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner;
11. The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at their participating hospitals.

Note: It is recommended the Cover Sheet be include in front of the Access Plan and submitted as one file. In this case the file name for Access Plans should be the HIOS Issuer ID followed by "Access Plan" and any additional information deemed appropriate. For example, 12345_Access_Planv3. If a Cover Sheet is submitted as a separate file from the Access Plan the file name should be Issuer ID followed by "Access Plan Cover Sheet" and any additional information deemed appropriate. For example, 12345_Access_Plan_Cover_Sheetv3.

Benefits and Service Area Module

Users of the Benefits and Service Area Module are assigned to one or both of the following roles: Benefits Submitter, an individual who submits the data and information necessary to complete the Benefits Module, and Benefits Validator, an individual who is responsible for validating the correctness of the data and information necessary to complete the Benefits Module.

There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (see Figure 2-1).

Figure 2-1. Three Tabs to Benefits and Service Area Module



The Data Submitter page allows Submitters to work on an existing application or view an already submitted application (see Figure 2-2). The Data Validator page allows Validators to view a list of all the applications that have been submitted. This section also allows validators to upload supporting documentation and answer supplemental responses through HIOS (see Figure 2-3). The Final Submission page allows users to cross-validate data between modules and submit the QHP Application.

Each of these tabs is broken down further with information issuers need to enter to create a new application or edit an existing application. For the Data Submitter page, all sections listed in the lower section and to the left-hand side of the page need to be completed before moving on to the Data Validator pages.

Figure 2-2. Upload Documentation Page

Upload Documentation Update Status

Fields marked with an asterisk (*) are required.
Please note that uploading a second version of the template or supporting document(s) will replace the previously uploaded version.

Document Type:	Actions	File Name	Description	Last Update	Status
*Plan & Benefits Template (SHOP)	Upload		<input type="text"/>		
*Plan & Benefits Template (Individual)	Upload		<input type="text"/>		
Dental Plan & Benefits Template (SHOP)	Upload		<input type="text"/>		
Dental Plan & Benefits Template (Individual)	Upload		<input type="text"/>		
*Network ID Template	Upload		<input type="text"/>		
*Service Area Template	Upload		<input type="text"/>		
Prescription Drugs Template	Upload		<input type="text"/>		
Select document type	Upload		<input type="text"/>		

Showing 1 to 8 of 8 entries
Add Another Document

Figure 2-3. Data Validator Page

Data Submitter
Data Validator
Final Submission

Please review the completed templates and supplementary documents.
Fields marked with an asterisk (*) are required.

Document Type:	File Name	Description	Last Update	Status
*Plan & Benefits Template (SHOP)	87296_NC_2016_PB_Med_SHOP.xls		02/17/2015 3:53:01 PM	Complete
*Plan & Benefits Template (Individual)	87296_NC_2016_PB_Med_Ind.xls		02/17/2015 3:52:52 PM	Complete
Dental Plan & Benefits Template (SHOP)	87296_NC_2016_PB_Dent_SHOP.xls		02/17/2015 3:52:32 PM	Complete
Dental Plan & Benefits Template (Individual)	87296_NC_2016_PB_Dent_Ind.xls		02/17/2015 3:52:38 PM	Complete
*Network ID Template	87296_NC_2016_Network.xls		02/17/2015 3:46:42 PM	Complete
*Service Area Template	87296_NC_2016_ServiceArea.xls		02/17/2015 3:46:53 PM	Complete
Prescription Drugs Template	87296_NC_2016_PrescriptionDrugs.xls		02/17/2015 3:49:51 PM	Complete

Showing 1 to 7 of 7 entries

Section 2A: Network ID

1. Introduction

In the Network ID section, issuers must assign each of their provider networks—groups of providers providing services in an area—to network IDs and provide the network URL that enrollees will use to access information about the issuer’s provider networks. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID;
2. List of provider networks; and
3. URLs for provider directory.

3. Quick Reference

Key Changes for 2018
◆ No changes for the 2018 QHP Application

Tips for the Network ID Section
<ul style="list-style-type: none"> ◆ The URL to the provider directory is the only network identification information made public. ◆ Dual-product issuers offering QHPs and SADPs must create two different network IDs for use with the two plan types, regardless of whether the network is intended to serve QHPs and SADPs. ◆ Dual-product issuers must use the word “dental” in the network area name for their dental service area to distinguish the QHP network from the dental network.

4. Detailed Section Instructions

Perform the following steps to complete the Network ID Template.

Network ID Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Using the drop-down menu, select the state in which the proposed plan will be offered.
Generate Network IDs	Click the Create Network IDs button. This button generates the network IDs that will be used in a later step. When asked how many networks, enter the number of networks, and select OK . The network IDs are automatically generated on the basis of the number of networks specified.
Network Name	Enter a network name. Dual-product issuers must use the word “dental” in the network name for their dental network to distinguish the QHP network from the dental network.
Network ID	Select a network ID using the drop-down menu. The network IDs consist of the state abbreviation plus an “N” and then a sequenced number (such as MDN001 or MDN002). Dual-product issuers offering QHPs and SADPs must create separate network IDs for their QHP and dental networks.
Network URL	Enter the network URL (website). The network URL is the web address on the issuer website that consumers use to view the providers in the issuer’s network associated with the specific identified network.

Repeat these steps for each additional network ID.

A sample completed **Network ID** Template looks like Figure 2A-1.

Figure 2A-1. Sample Network ID Template

2018 Network Template v7.0		<i>All fields with an asterisk (*) are required.</i>
<input type="button" value="Validate"/>		<i>To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.</i>
<input type="button" value="Finalize"/>		<i>Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.</i>
		<i>Network IDs will populate in the drop-down box in Network ID column.</i>
		<i>Use each Network ID only once.</i>
HIOS Issuer ID*	12345	
Issuer State*	VA	
<input type="button" value="Create Network IDs"/>		
Network Name* Required: Enter the Network Name	Network ID* Required: Select the Network ID	Network URL* Required: Enter the Network URL
Smith Network	VAN001	https://SmithNetwork1.com

Once the template is completed, issuers must validate, finalize, and upload it into HIOS.

<i>Template Validation</i>	<i>Steps</i>
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML version of the template that issuers need to upload in the network section of the Benefits and Service Area Module.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the network section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this step.

Section 2B: Service Area

1. Introduction

In the Service Area section, issuers will need to identify the service areas associated with their QHPs, SADPs, or both, by state and county. These instructions apply to QHP and SADP issuers, and both types of issuers are required to submit the Service Area Template as part of their QHP Application.

To indicate the geographic coverage of each QHP, SADP, or both and to demonstrate compliance with the county integrity requirements under 45 CFR 155.1055, issuers must identify proposed service areas in their application. The service area of a QHP or SADP is the geographic area where the plan accepts members, if it limits membership based on where people live.

In almost all situations, HHS will approve only service areas covering full counties. In the rare case in which the issuer proposes a service area covering a partial county, additional justification is required.

2. Data Requirements

The service area section of the QHP Application comprises three parts:

1. A template for identifying the issuer's service area, and any included counties and ZIP codes as applicable, if the entire state is not covered.⁴
2. A detailed partial county supplemental response, if applicable (the recommended form is available at <https://www.qhpcertification.cms.gov/s/Service%20Area>.)
3. If applicable, written evidence from the appropriate FFM state regulator indicating that the partial county is approved by the state.

To complete the template for this section, an issuer needs the following information:

1. HIOS Issuer ID;
2. Issuer state;
3. Names and IDs for proposed service areas to be associated with the issuer's QHPs or SADPs;
4. Names of counties that the issuer is applying to cover, if electing not to include an entire state in a service area; and
5. ZIP codes in any county that the issuer is applying to cover when electing not to include an entire county in a service area.

3. Quick Reference

Key Changes for 2018

- ◆ Issuers in states that perform plan management functions and file through SERFF are strongly encouraged to submit a Microsoft Excel version of their Service Area Template.

⁴ The columns these data are entered in appear in the Excel template when "Yes" is selected for Column E.

Tips for the Service Area Section

- ◆ Issuers may not change their service area after their initial submission, unless they submit a petition to do so, and they may make this change only during the time frame specified by CMS. This includes issuers submitting through SERFF, even if the issuer is responding to a deficiency issued by the state. See the Service Area Petition Process in the Review Periods and Revision Process section for more information.
- ◆ Dual-product issuers offering QHPs and SADPs must create two different service area IDs for use with the two plan types, regardless of whether the service area is intended to serve both QHPs and dental plans.
- ◆ Dual-product issuers must use the word “dental” in the service area name for their dental service area to distinguish the QHP service area from the dental service area.
- ◆ Excel template file names must be all lowercase and cannot contain spaces. For example, “servicearea_data” is a valid template file name, but “ServiceArea_data” or “service area data” are not valid template file names.
- ◆ Name the partial county justification, if applicable, using the following naming convention: [HIOS Issuer ID]_[State]_service_area_partial_county, for example, “12345_MD_service_area_partial_county.pdf.”
- ◆ When deciding how to establish service areas, consider existing health care delivery markets in the states in which the issuer is applying to offer plans. If people in a rural county generally travel a long distance to see a health care provider or dentist and the distance is consistent with practices permitted by the state, it may not be necessary to have a contracted provider in all parts of the rural county. In these cases, issuers may want to consider establishing a service area for the entire state, giving members in the more rural part of the county the option to see providers in other ZIP codes. Alternatively, an issuer may elect to exclude an entire county from its service area if no providers are available in the excluded ZIP codes.
- ◆ A service area can be associated with multiple plans. For example, an issuer has five plans and four service areas. The first plan has a service area (SA001) that covers the entire state. The second and third plans have a service area (SA002) that covers Counties A and B. The fourth plan has a service area (SA003) that covers Counties C and D. The fifth plan has a service area (SA004) that covers Counties A, B, C, and D.
- ◆ A QHP or SADP must always be associated with a single Service Area ID and with a single Network ID, but networks and service areas may be used for multiple QHPs or SADPs. The issuer creates one template for all of its service areas and identifies each service area with a unique Service Area ID. The issuer also completes the Network ID Template and creates a unique Network ID for each network. When the issuer completes the Plans & Benefits Template, it maps each plan to a specific Service Area ID and Network ID as entered in the Service Area and Network ID Templates. Service Area IDs and Network IDs may both be used for multiple plans and do not have to correspond one to one (for example, an issuer may have a single state-wide network, identified with a Network ID, assigned to all of its plans, but have two Service Area IDs, each made up of half the state and each assigned to a different plan).
- ◆ The Marketplace does not require an issuer’s service area to cover a complete rating area. However, issuers are also bound by state service area requirements, so carefully review the state guidance on this topic to ensure the proposed service areas comply with state requirements. Multiple rating areas are allowed within a service area as specified by the state. Separate Service Area IDs are not required even if a service area is made up of multiple rating areas.

4. Detailed Section Instructions

The following steps are taken to complete the Service Area Template.

Service Area Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which the issuer is intending to offer coverage using the drop-down menu.
Service Area ID	<p>Click the Create Service Area IDs button at the top of the Service Area Template. Service area IDs must be generated by the template.</p> <p>Enter the total number of desired service areas for the identified state. Each plan must be associated with a single service area ID, but a service area ID can be associated with multiple plans. The template automatically adds service area IDs to the <i>Service Area ID</i> drop-down menu. For example, if the issuer enters “3” for the total number of service areas, the template automatically generates three service area IDs. If the proposed service area covers the entire state, enter “1” for the number of service areas. The <i>Service Area ID</i> consists of the state abbreviation plus an “S” and then a sequenced number (MDS001 or MDS002, for example).</p> <p>In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.</p>
Service Area Name	<p>Enter a name for the service area selected.</p> <p>Note: It may be helpful to name the service area so that it identifies a plan characteristic, such as health maintenance organization (HMO), or the actual plan name.</p> <p>Dual-product issuers must use the word “dental” in the service area name for their dental service area to distinguish the QHP service area from the dental service area. The <i>Service Area Name</i> will not be displayed to the public on www.HealthCare.gov.</p>
State	<p>Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the service area includes the entire state. No additional information is required for the identified service area. Continue adding service areas until all service areas have been identified. ◆ No—if the service area includes only certain counties in the state. In the next step, county information must be provided for the identified service area. Continue adding service areas and counties as appropriate until all service areas have been identified. <p>Note: The same <i>Service Area ID</i> <u>cannot</u> be used for both a service area that covers the entire state <u>and</u> for a service area that covers only certain counties in the state.</p>
County Name	<p>Use the drop-down menu to select the name of each county included in the identified service area if the issuer indicated above that the identified service area does not cover the entire state.</p> <p>If a service area includes multiple counties, the issuer must add a new row for each new county using the same service area ID and service area name.</p> <p>If the issuer’s service area counties do not appear in the drop-down menu, please contact the Help Desk at 855-CMS-1515 or via e-mail at CMS_FEPS@cms.hhs.gov.</p>
Partial County	<p>Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No—if the service area includes the entire county. No additional information is required for the identified county. ◆ Yes—if the service area covers only part of the county. If Yes is selected, an informational box appears showing the HHS partial county policy. Select OK. A <i>Service Area ZIP Code(s)</i> column and a <i>Partial County Justification Filename</i> column will appear on the template.

Service Area Template	Steps
Service Area ZIP Code	Enter the five-digit ZIP codes included in the partial county if the issuer identified that the county is only partially covered. If entering more than one ZIP code, use a comma to separate each ZIP code. The ZIP codes entered are validated after the template is uploaded.
Partial County Justification Filename	Enter the file name for the partial county justification supplemental response. Use the following naming convention: [HIOS Issuer ID]_[State]_service_area_partial_county. For example, "12345_MD_service_area_partial_county.pdf."

A sample completed **Service Area** Template looks like Figure 2B-1.

Figure 2B-1. Sample Service Area Template

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Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code(s)	Partial County Justification Filename
MDS004 Service Area Four		Yes				
MDS001 Service Area One		No	Cecil - 24015	Yes	21921, 21919, 21911	12345_MD_service_area_partial_county.pdf
MDS001 Service Area One		No	Harford - 24025	No		
MDS001 Service Area One		No	Baltimore - 24005	No		
MDS001 Service Area One		No	Kent - 24029	Yes	21661, 21620, 21645, 21678	12345_MD_service_area_partial_county.pdf
MDS002 Service Area Two		No	Dorchester - 24019	No		
MDS003 Service Area Three		No	Prince Georges - 24033	Yes	20785, 20786, 20784	12345_MD_service_area_partial_county.pdf

The following steps are taken if the issuer is requesting to serve a partial county (i.e., the issuer selected **Yes** to one or more counties in Column E of the Service Area Template.

Partial County Justification Supplemental Response
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. For each requested exception, the issuer must submit a detailed supplemental response substantiating why the entire county will not be served. The issuer must justify that the partial county service area is necessary, non-discriminatory, and in the best interests of potential enrollees and the Marketplace program, consistent with 45 CFR 155.1055.
The specific questions to be answered are on the recommended form found at https://www.ghcpertification.cms.gov/s/Service%20Area . Failure to respond to each of these questions will result in the denial of the partial county request.
Issuers may request partial county service areas from CMS only with state authorization. Issuers in FFM states that complete the QHP Application in HIOS should provide written evidence that their appropriate state regulator has authorized their partial county service area, such as an e-mail that lists the specific ZIP codes in the partial county requested.
Issuers in states performing plan management functions that request to serve partial counties must submit a partial county supplemental response but are not required to submit evidence of state approval. Successful transmission of the data will serve as state approval of the partial county request.

Partial County Justification Supplemental Response

After completing the supplemental response form, do the following:

- ◆ Combine written evidence that the appropriate FFM state regulator has authorized the partial county service area and the partial county justification supplemental response into one PDF file.
- ◆ Name the PDF file using the following convention: [HIOS Issuer ID]_[State]_service_area_partial_county. For example, "12345_MD_service_area_partial_county.pdf." Enter this file name in Column G, "Partial County Justification Filename" of the Service Area Template.
- ◆ Upload the combined document in the plans and benefits section of the Benefits and Service Area Module in HIOS using the document upload functionality. Select the document type **Service Area Justification** from the *Document Type* drop-down menu.

Once the Service Area Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML version of the template that issuers need to upload in the Service Area section of the Benefits and Service Area Module in HIOS.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the Service Area section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this step.

Section 2C: Prescription Drug

1. Introduction

In the Prescription Drug section, issuers must create cost sharing for each tier of drug benefits along with specific drugs included in the formulary. They must also select the drugs that are to be offered at each tier level. These instructions apply only to QHP issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. Formulary URLs. Enter the website location for formulary information. URLs must start with “http://” or “https://” to work properly for the consumer.
2. A drug list with RxNorm Concept Unique Identifiers (RxCUIs), along with their formulary tier numbers. An issuer may offer drugs that do not have associated RxCUIs, but they cannot be included on the Prescription Drug Template.⁵

3. Quick Reference

Key Changes for 2018

- ◆ No major changes for the 2018 QHP Application.

Tips for the Prescription Drug Section

- ◆ RxCUIs should have one of the following Term Types (TTY): semantic branded drug (SBD), semantic clinical drug (SCD), brand name pack (BPCK), or generic pack (GPCK).
- ◆ Set *Tier Level* equal to NA (not applicable) if the drug is not part of a given drug list.
- ◆ All formularies associated with the same drug list should have the same *Number of Tiers* and the same *Drug Tier Type* for a given tier. In other words, each drug list may have only one tier structure, as indicated by the number of tiers and drug tier types. The XML generated from the template and submitted to HIOS includes only the *Number of Tiers* and *Drug Tier Type* fields for the first formulary associated with each drug list.

4. Detailed Section Instructions

Issuers need to complete the Drug Lists worksheet before they fill out the Formulary Tiers worksheet in the template. An example is shown Figure 2C-1.

⁵ Pursuant to 45 CFR 156.122(a)(3), for plan years beginning on or after January 1, 2017, a health plan does not provide EHBs unless it uses a pharmacy and therapeutics (P&T) committee that meets certain standards.

Figure 2C-1. Drug List Worksheet

Drug Lists							
All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.							
Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.							
After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.							
Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.							
Enter all RxCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).							
Drug List ID 1				Drug List ID 2			
RxCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required	
Required: Enter the RxCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
405550	3	No	No		3	No	No
405551	2	No	Yes	NA			
405552	1	No	No		1	No	No
405553	1	No	No		1	No	No
405554	2	No	No		2	No	No
405555	3	No	No		3	No	No
405556	3	No	No		3	No	No
405557	2	No	No	NA			
405558	1	No	No	NA			
405559	1	No	No		1	No	No
405560	2	No	No		2	No	No
405561	3	No	No		3	No	No
405562	3	No	No		3	No	No
405563	2	No	No		2	No	No
405564	1	No	No		1	No	No
405565	1	No	No	NA			
405566	2	No	No		2	No	No
405567	3	No	No		3	No	No
405568	3	No	No		3	No	No

Before entering details for each drug list, enter all RxCUIs included in any of the drug lists. RxCUIs are entered into Column A, beginning in Row 9. Once the issuer has entered all of the unique RxCUIs for its drug lists, it should begin entering the drug-list-specific information in each row.

Drug List	Steps
RxCUI	<ul style="list-style-type: none"> When selecting RxCUIs to include, use the October 3, 2016, full monthly release of RxNorm to find a list of valid RxCUIs. Download the RxNorm release at https://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html. To download the file, the issuer will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. The issuer can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. CMS anticipates posting the EHB Rx Crosswalk and a reformatted RxNorm database along with the state review tools at https://www.qhpcertification.cms.gov/s/Review%20Tools. RxCUIs should have one of the following Term Types (TTY): SBD, SCD, BPCCK, or GPCK. The drug list should include all drugs on the issuer's formulary, even if they do not fall in one of the categories and classes identified in the summary of EHB benchmark information, available at https://www.qhpcertification.cms.gov/s/Prescription%20Drugs. This includes all drugs deemed by the user as "medical service drugs."
Tier Level	For each drug, select the RxCUI's cost sharing tier level from the drop-down menu, or select NA if this drug is not part of the given drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following options: <ul style="list-style-type: none"> Yes—if prior authorization is required. No—if prior authorization is <u>not</u> required. If <i>Tier Level</i> is NA , leave this column blank.

Drug List	Steps
Step Therapy Required	<p>Indicate whether the plan requires the enrollee to try at least one other drug before the plan covers the given drug. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if step therapy is required. ◆ No—if step therapy is <u>not</u> required. <p>If <i>Tier Level</i> is NA, leave this column blank.</p>

To add another drug list, click the **Add Drug List** button (Figure 2C-2). For the new drug list, issuers need to complete the *Tier Level*, *Prior Authorization Required* and *Step Therapy Required* columns as described above. Once an issuer has completed the *Tier Level*, *Prior Authorization Required*, and *Step Therapy Required* columns, it has completed the required information for its drug list.

Figure 2C-2. Add Drug List Button

Drug Lists		All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.					
Add Drug List		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.					
Remove Drug List		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.					
		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).					
		Drug List ID 1			Drug List ID 2		
RXCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required	
Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3 No	No		3 No	No	
10	405551	2 No	Yes	NA			
11	405552	1 No	No		1 No	No	
12	405553	1 No	No		1 No	No	

If an issuer needs to remove a drug list, click the **Remove Drug List** button (Figure 2C-3). Drug lists are removed in the reverse order in which they were created. In other words, the last drug list created is removed first. If the issuer wants to remove a drug list that is not the last drug list created (for example, if there are four drug lists and the issuer wants to remove the second one), copy and paste the data from the last drug list into the drug list that the issuer wants to delete; then click the **Remove Drug List** button.

Delete any drug lists that are not used. A drug list that is not used links to a *Formulary ID* that does not link to a *Standard Component ID* in the Plans & Benefits Template. When removing drug lists, make sure that all remaining Formulary IDs are linked to the correct drug lists.

Figure 2C-3. Remove Drug List Button

Drug Lists		All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.					
Add Drug List		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.					
Remove Drug List		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.					
		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).					
		Drug List ID 1			Drug List ID 2		
RXCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required	
Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3 No	No		3 No	No	
10	405551	2 No	Yes	NA			
11	405552	1 No	No		1 No	No	
12	405553	1 No	No		1 No	No	

Once the Drug Lists worksheet is completed, go to the Formulary Tiers worksheet.

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Select the state for which the template applies from the drop-down menu.
Generate Formulary IDs	<p>Click the Create Formulary IDs button to create the Formulary IDs.</p> <ul style="list-style-type: none"> ◆ A pop-up dialog box appears and prompts the issuer to enter the number of formularies. ◆ After entering the number of formularies, the message “Formulary IDs have been generated successfully” appears. Click OK. The IDs are automatically generated, consisting of the state abbreviation plus an “F,” and then a sequenced number (such as ALF001 and ALF002). ◆ Once completed, the Formulary IDs appear in a drop-down menu in the <i>Formulary ID</i> column.
Formulary ID	<p>Select the Formulary ID from the drop-down menu.</p> <ul style="list-style-type: none"> ◆ After a Formulary ID is selected, the template populates some cells and grays out others that do not apply. When a cell is grayed out, it is locked and cannot be edited. The QHP Application System will not process data entered into the cell before it was grayed out. ◆ Select only Formulary IDs that will be linked to a Standard Component ID used in the Plans & Benefits Template.
Formulary URL	<p>Enter the URL (web address) for the formulary document or website. CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, specific to a given QHP. The URL provided to the Marketplace as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer’s website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHPs. CMS makes issuer-provided formulary links available to consumers on HealthCare.gov.</p>
Drug List ID	<p>Select the appropriate Drug List ID from the drop-down menu. The menu is auto-populated with the Drug List IDs that were created on the Drug List worksheet. If the Drug List worksheet has not been completed, do so now.</p>
Number of Tiers	<p>Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary should correspond to the number of tiers in the associated drug list. Cost sharing subgroups cannot be created within a tier. All drugs within the same tier should have the same cost sharing.</p>
Drug Tier ID	<p>The template populates this column according to the selection in <i>Number of Tiers</i>. The other cells are grayed out, indicating they do not apply. The <i>Drug Tier ID</i> column is controlled by the template; do not edit it.</p>
Drug Tier Type	<p>Click the drop-down menu, and select the Click here to select option to open a pop-up dialog box. Choose from the following options, and select a maximum of two drug types, one generic type and one brand type for each tier. No additional tier type can be selected for Zero Cost Share Preventive Drugs. No additional tier type can be selected for Medical Service Drugs.</p> <ul style="list-style-type: none"> ◆ If a tier contains both preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, then choose the tier type of preferred generic. The same applies for a tier with preferred and non-preferred brand drugs. ◆ Multiple tiers may have the same drug tier types, but tiers should have different cost sharing.

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ If the issuer has both preferred and non-preferred specialty drugs, create two tiers and differentiate between the two using cost sharing. One way to represent this design is to designate the first as Preferred Brand, Specialty and the second as Non-Preferred Brand, Specialty. <p>Zero Cost Share Preventive Drugs:</p> <ul style="list-style-type: none"> ◆ When Zero Cost Share Preventive Drugs is selected, it is the only tier type that can be selected for the tier. It is preferred that the issuer place the Zero Cost Share Preventive Drug tier as Tier 1 if applicable, to represent the lowest-cost tier to the consumer. ◆ The <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i> information will automatically be set to \$0 and 0 percent, respectively, when this tier type is chosen. The remaining pharmacy benefit types can still be edited. If the remaining pharmacy benefits are offered, then the subsequent cost sharing fields should be entered as \$0 and 0 percent. ◆ If the issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost sharing fields for the most typical or most used benefit cost share design. Describe any cost sharing features that do not directly fit into the Prescription Drug Template in the <i>Explanation</i> field of the Plans & Benefits Template and in a plan brochure and <i>Formulary URL</i>. <p>Medical Service Drugs:</p> <ul style="list-style-type: none"> ◆ Use this tier type to indicate if a formulary contains medical service drugs. CMS recognizes that there are some state benchmarks that contain medical service drugs in various categories and classes; therefore, a Medical Service Drugs tier can assist in identifying these drugs in the formulary. ◆ When Medical Service Drugs is selected, it is the only tier type that can be selected for the tier. ◆ The <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i> will both be automatically set to Not Applicable when this tier type is chosen. The remaining pharmacy benefit types cannot be edited.
Tier Cost Sharing	<p>This section describes how to document the cost sharing structure for each drug tier. The only columns that must be populated are <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i>. Complete the information for the other three pharmacy types only if they apply to the given drug tier, but the issuer must indicate whether each tier offers these types of pharmacy benefits. The pharmacy benefits are as follows:</p> <ul style="list-style-type: none"> ◆ 1 Month In Network Retail Pharmacy (Copayment & Coinsurance) ◆ 1 Month Out of Network Retail Pharmacy Benefit Offered? ◆ 1 Month Out of Network Retail Pharmacy (Copayment & Coinsurance) ◆ 3 Month In Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month In Network Mail Order⁶ Pharmacy (Copayment & Coinsurance) ◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance).
Benefit Offered	<p>Select Yes if the pharmacy benefit is offered for the corresponding tier. Otherwise, select No.</p>
Copayment	<p>Enter the copayment amount for the given pharmacy type. The copayment field allows values to the hundredths decimal. Round any copayments to the hundredths decimal. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, <u>not</u> No Charge, should be used if only a coinsurance is charged.

⁶ Pursuant to 45 CFR 156.122, for plan years beginning on or after January 1, 2017, a health plan providing EHBs at in-network retail pharmacies, unless the drug meets an exception under 45 CFR 156.122(1)(i) and (ii).

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. Note that when using Not Applicable for copay, Not Applicable cannot be used for coinsurance (unless the drug tier type is Medical Service Drugs).
Coinsurance	<p>Enter the coinsurance amount for the given pharmacy type. The coinsurance field allows values to the hundredths decimal. Round any coinsurance to the hundredths decimal. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, <u>not</u> No Charge, should be used if only a copay is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ X% Coinsurance after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a copay. Note that when using Not Applicable for coinsurance, Not Applicable cannot be used for copay (unless the drug tier type is Medical Service Drugs).

Issuers should complete cost-sharing fields in the Prescription Drug Template for the most typical or most used benefit cost share design. Issuers can describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the *Explanation* field of the Plans & Benefits Template and in a plan brochure and *Formulary URL*.

CMS will review tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing their formulary tier structure, issuers should use standard industry practices. Tier 1 should be considered the lowest cost sharing tier available, which means a Zero Cost Share Preventive tier should be listed first. Any and all subsequent tiers with the formulary structure will be higher cost sharing tiers in ascending order. Place the Medical Service Drug tier as the last tier for all formulary designs.

Preventive services under the ACA must be covered without the consumer having to pay a copayment or coinsurance or meet a deductible. For more information on the coverage of preventive services, see <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/#Prevention> and http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html.

CMS recommends that issuers place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template. If an issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost-sharing fields for the most typical or most used benefit cost share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the *Explanation* field of the Plans & Benefits Template and in a plan brochure and *Formulary URL*.

If an issuer has already used all seven available tiers, include zero cost preventive drugs in the lowest cost tier and clearly identify in the plan brochures and *Formulary URL* that these drugs are available at zero cost sharing because all drugs within the same tier should have the same cost sharing.

Alternatively, if an issuer has already used all seven available tiers and one of the tiers is a medical service drug tier, include the zero cost preventive drugs as a tier and remove the medical service drug tier.

If an issuer has a tier cost share of zero and it is not a preventive tier, then the issuer may either select **No Charge** for *Copayment* and **Not Applicable** for *Coinsurance* or **Not Applicable** for *Copayment* and **No Charge** for *Coinsurance* in the Formulary Tiers worksheet. Note that an issuer cannot use **Not Applicable** for both *Copayment* and *Coinsurance* at the same time.

The Prescription Drug Template does not capture minimum or maximum copay or coinsurance. CMS recommends that issuers describe in detail any cost sharing designs that are not captured in the Prescription Drug Template in the *Explanation* field of the Plans & Benefits Template and in a plan brochure and *Formulary URL*.

Once the Prescription Drug Template is completed, issuers must validate, finalize, and upload it into HIOS.

<i>Template Validation</i>	<i>Steps</i>
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML file of the template that will need to be uploaded in the Prescription Drug section of the Benefits and Service Area Module in HIOS.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved XML file in the Prescription Drug section of the Benefits and Service Area Module in HIOS. Refer to the Benefits and Service Area Module User Guide for details on how to complete this.

Section 2D: Plans & Benefits

1. Introduction

In the Plans & Benefits section, issuers will enter data about their plans and list covered benefits with any quantitative limits or exclusions. They will also provide cost sharing and basic plan variation information for each plan that is being submitted, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. These pieces of information will be included through two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, the issuer will need the following:

1. Completed Network ID (QHP & SADP), Service Area (QHP & SADP), and Formulary Excel Templates (QHP only);
2. Applicable plan URLs; and
3. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2018

- ◆ There is a new *Level of Coverage* option called “Expanded Bronze.” This metal level’s AV has a de minimis range of 56 percent to 65 percent and should be used for plans that either cover and pay for at least one major service—other than preventive services—before the deductible, or meet the requirements to be a high deductible health plan. “Expanded Bronze” will appear as the *Level of Coverage* on the Benefits Package and Cost Share Variances worksheets; however, the plan will show as just “Bronze” to consumers.
- ◆ The cost sharing drop down “\$X copay with deductible” will now take the place of the option “\$X copay before deductible” that was shown in previous years. This cost sharing option means the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible.
- ◆ There are now three sets of Simple Choice plan options that vary by state. Set 2 is for DE, IA, KY, LA, MO, MT, and NH; Set 3 is for NJ; and Set 1 is for all the other states. Each issuer should use the Simple Choice plans applicable to its specific state.

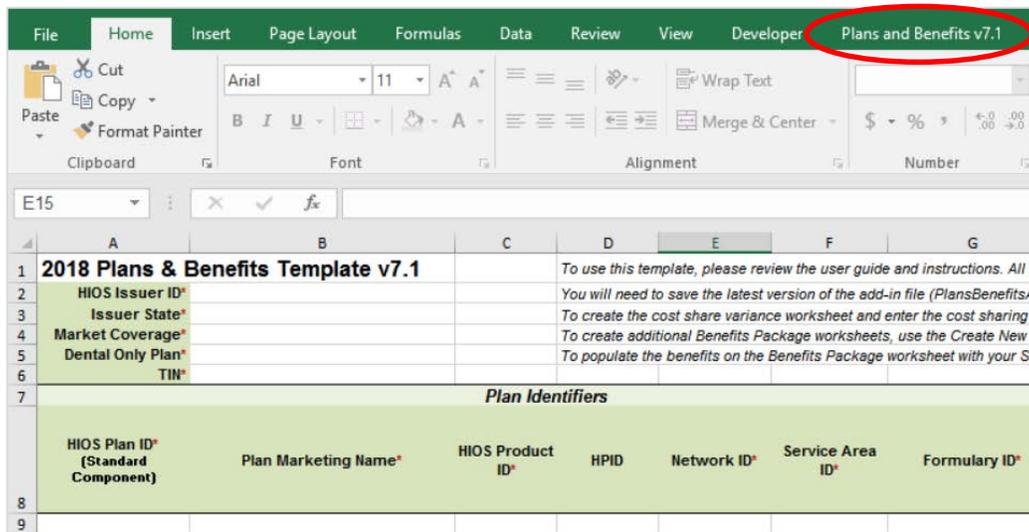
Tips for the Plans & Benefits Section

- ◆ Download the most recent versions of the 2018 Plans & Benefits Template, Add-In file, Actuarial Value Calculator (AVC), and Simple Choice Plan Add-In file.
- ◆ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template for the macros to run properly.
- ◆ All data elements that CMS anticipates displaying to individual market consumers on Plan Compare are **identified by a number symbol (#)** next to the field name.
- ◆ All data fields required for SADP issuers are **identified by an asterisk (*)** next to the field name. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variance worksheet, see Sections 4.11, 4.20–4.22, 4.24, 4.26, and 4.27.
- ◆ All data fields used by the AVC are **identified by a caret (^)** next to the field name. See the Appendix for additional AVC instructions.
- ◆ The issuer should complete the Network, Service Area, and Prescription Drug Templates (QHPs only) and save them to its computer before filling out the Plans & Benefits Template. This template requires issuers to assign a network, service area, and formulary ID to each plan on the basis of the IDs already created in these three templates.
- ◆ Complete a separate Benefits Package worksheet for each unique benefits package the issuer wishes to offer. To create additional benefits packages, click the Create New Benefits Package button on the menu bar under the Plans & Benefits ribbon. The *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, *Dental Only Plan*, and *TIN* fields are auto-populated.
- ◆ Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost sharing reduction plan variation the issuer wishes to offer.
- ◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Appendix 1 for how these values relate to AV.
- ◆ When a cell is grayed out, it is locked and cannot be edited. The Benefits and Service Area Module will not process data entered into the cell before it was grayed out.

4. Detailed Section Instructions

When opening the Plans & Benefits Template, if the issuer is asked to enable macros, use the **Options** button on the Security Warning toolbar, and select **Enable this content**. If the macros are not enabled before the data are entered, the template will not recognize those data fields and they will have to be reentered. Once the issuer does this, the **Plans & Benefits** and **Simple Choice Plan** ribbons should appear (Figure 2D-1) as tabs on the file's toolbar. **Note:** The **Simple Choice Plan** Add-In will not automatically load into the Plans & Benefits Template and must be opened before the ribbon will appear.

Figure 2D-4. Plans & Benefits Ribbon



Before proceeding, the issuer should confirm that it has downloaded the latest versions of the Plans & Benefits Template and both Add-In files from the Centers for Consumer Information and Insurance Oversight (CCIIO) website (<https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>).

4.1 General Information

The fields in the upper-left portion of the Benefits Package worksheet contain basic information about the issuer and the types of plans to be entered into the template (Figure 2D-2). This information must be entered in the first Benefits Package worksheet; it will then auto-populate any additional Benefits Package worksheets generated by the issuer.

Figure 2D-5. Plans & Benefits Template

2018 Plans & Benefits Template v7.1	
HIOS Issuer ID*	
Issuer State*	
Market Coverage*	
Dental Only Plan*	
TIN*	

General Plans & Benefit Information	Steps
HIOS Issuer ID *	Enter the five-digit HIOS Issuer ID.
Issuer State *	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage *	Select the market coverage. Choose from the following options: <ul style="list-style-type: none"> ◆ Individual—if the plans are offered on the individual market. ◆ SHOP (Small Group)—if the plans are offered on the small group market.
Dental Only Plan *	Indicate whether the plans contained in the template are dental only plans. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if this is a dental only package. When “Yes” is selected, the template grays out areas that do not apply to SADPs and prevents the field from accepting data entry. ◆ No—if this is <u>not</u> a dental only package.
TIN *	Enter the issuer’s 9-digit (xx-xxxxxxx) Tax Identification Number (TIN).

4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data on each plan, including its Plan ID and the network, service area, and formulary (QHPs only) it uses (Figure 2D-3). Complete this section for each standard plan the issuer plans to offer as part of this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage (low or high level of coverage for SADP), and a benefits package is a group of plans that covers the same set of benefits. Each plan in a benefits package may have different cost sharing values, which are entered in the corresponding Cost Share Variances worksheet. Enter each standard plan in the Benefits Package worksheet, and the template automatically creates the necessary plan variations in the Cost Share Variances worksheet.

If the issuer runs out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans & Benefits** ribbon. Each benefits package may have up to 50 plans. If there are more than 50 plans associated with the same benefits package, a new benefits package with the identical benefits package structure must be created.

Figure 2D-6. Plan Identifiers Section

2018 Plans & Benefits Template v7.1		To use this template, please review the user guide and instructions. All field
HIOS Issuer ID*		You will need to save the latest version of the add-in file (PlansBenefitsAddIn)
Issuer State*		To create the cost share variance worksheet and enter the cost sharing amount
Market Coverage*		To create additional Benefits Package worksheets, use the Create New Benefits Package
Dental Only Plan*		To populate the benefits on the Benefits Package worksheet with your State
TIN*		
Plan Identifiers		
HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID* HPID Network ID* Service Area ID* Formulary ID*

Plan Identifiers	Steps
HIOS Plan ID (Standard Component) **	Enter the 14-character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name **	Enter the plan marketing name at the standard plan level.
HIOS Product ID *	Enter the 10-character, HIOS-generated Product ID number.
HPID *	Enter the 10-digit national Health Plan Identifier (HPID).
Network ID *	Click the Import Network IDs button on the menu bar under the Plans & Benefits ribbon, and select the completed Network Template Excel file to import a list of values from the Network Template; then select the appropriate one from the drop-down menu. (The Excel version of the Network ID Template must be completed and saved before importing the Network IDs.)
Service Area ID *	Click the Import Service Area IDs button on the menu bar under the Plans & Benefits ribbon, and select the completed Service Area Template Excel file to import a list of values from the Service Area Template; then select the appropriate one from the drop-down menu. (The Excel version of the Service Area Template must be completed and saved before importing the Service Area IDs.)
Formulary ID	Click the Import Formulary IDs button on the menu bar under the Plans & Benefits ribbon, and select the completed Prescription Drug Template Excel file to import a list of values from the Prescription Drug Template; then select the appropriate one from the drop-down menu. (The Excel version of the Prescription Drug Template must be completed and saved before importing the Formulary IDs.)

4.3 Plan Attributes

This section includes fields for inputting more specific data for each plan, including its type, its metal level, and other plan-level requirements (Figure 2D-4).

Figure 2D-4. Specific Data Fields for Plan Attributes

Plan Attributes							
Non-QHP*	Notice Required for Pregnancy*	Is a Referral Required for Specialist?*	Specialist(s) Requiring a Referral	Plan Level Exclusions	Limited Cost Sharing Plan Variation - Est Advanced Payment	Does this plan offer Composite Rating?*	Child-0

Plan Attributes	Steps
New/Existing Plan? *	Indicate whether this is a new or existing plan. Choose from the following options:

Plan Attributes	Steps
	<ul style="list-style-type: none"> ◆ New—if this is a new plan that was not offered last year. This includes a plan that was offered last year but is not considered to be the “same plan” as described in 45 CFR 144.103. These plans should use new Plan IDs that were <u>not</u> used for the 2017 plan year. ◆ Existing—if this plan was offered last year and the plan is considered to be the “same plan” as described in 45 CFR 144.103. These plans should use <u>the same</u> Plan ID that was used for the 2017 plan year.
Plan Type **	<p>Select the plan type that best corresponds to plan definitions provided in state law or regulations in the issuer’s state. Plan type selections must be consistent with the issuer’s state form-filing submissions. Choose from the following product network types:</p> <ul style="list-style-type: none"> ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point-of-service) ◆ EPO (exclusive provider organization)
Level of Coverage ^**	<p>Select the metal level of the plan on the basis of its AV. A de minimis variation of -4/+2 percentage points is allowed for standard metal-level plans. Please note that, pursuant to 45 CFR 156.200(c), QHP issuers must offer at least one QHP in the silver coverage level and one QHP in the gold coverage level in each county they cover through the Marketplace, as described in Section 1302(d)(1) of the ACA. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Bronze—AV of 60 percent. ◆ Expanded Bronze—AV of 56 percent to 65 percent. This is a new option for PY2018 with an expanded AV de minimis range. A plan may use this option if it either covers and pays for at least one major service, other than preventive services, before the deductible, or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2). ◆ Silver—AV of 70 percent. ◆ Gold—AV of 80 percent. ◆ Platinum—AV of 90 percent. ◆ Catastrophic—offered to certain qualified individuals and families; it does not meet a specific AV but must comply with several requirements, including the MOOP and deductible limits. <p>For SADP issuers, choose from the following:</p> <ul style="list-style-type: none"> ◆ Low—AV of 70 percent. ◆ High—AV of 85 percent.
Design Type*	<p>Indicate whether this plan will follow a Simple Choice plan design. An issuer may have up to five unique plans in each metal level that follow the Simple Choice plan design for that metal level. This designation is selected at the plan level but must be applied to all associated plan variations. For example, if the issuer selects “Design Type 1” for a silver plan, all of the corresponding silver plan variations must follow the cost sharing structure for their respective CSR Simple Choice plan designs. For more information on the Simple Choice plan design and populating plans’ cost sharing using the Simple Choice Plan Add-In, see Section 5.12. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Not Applicable—if this plan does <u>not</u> follow a Simple Choice plan design. ◆ Design Type 1—if this plan will be the first Simple Choice plan design for a metal level. ◆ Design Type 2—if this plan will be the second Simple Choice plan design for a metal level. ◆ Design Type 3—if this plan will be the third Simple Choice plan design for a metal level.

Plan Attributes	Steps
	<ul style="list-style-type: none"> ◆ Design Type 4—if this plan will be the fourth Simple Choice plan design for a metal level. ◆ Design Type 5—if this plan will be the fifth Simple Choice plan design for a metal level. An issuer may offer up to five plans with the Simple Choice plan design at each of the bronze, silver, and gold metal levels. The plans must meet meaningful difference requirements under 45 CFR 156.298 but may differ with respect to other features, such as product type (e.g., HMO vs. PPO), provider network, drug formulary, or additional benefits covered (e.g., adult dental). SADPs and SHOP plans should select Not Applicable for this field.
Unique Plan Design	<p>Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available for HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix 1. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the unique plan design features cause the use of the AVC to yield an AV result that materially differs from that of the other approved methods described in 45 CFR 156.135(b). This indicates that the plan is not compatible with the AVC. If Yes is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification (see Supporting Document section). The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice. ◆ No—if the plan design is <u>not</u> unique.
QHP/Non-QHP*	<p>Indicate whether the plan will be offered only outside the Exchange or whether the plan will be offered through and outside the Exchange. (An Exchange is also known as a Marketplace.) Choose from the following options:</p> <ul style="list-style-type: none"> ◆ On the Exchange—under the guaranteed availability requirements in 45 CFR 147.104, a plan offered through the Marketplace generally must be available to individuals and employers (as applicable) in the state who apply for the plan outside the Marketplace. Issuers that offer a plan through the Marketplace should select the “Both” option below unless an exception to guaranteed availability applies. ◆ Off the Exchange—if the plan will be offered only outside the Marketplace. This includes non-QHPs as well as plans that are substantially the same as a QHP offered through the Marketplace for purposes of the risk corridor program (see 45 CFR 153.500 for more details). ◆ Both—if the plan will be offered both through and outside the Marketplace. A plan that is offered both through and outside the Marketplace must have the same premium, provider network, cost sharing structure, service area, and benefits, regardless of whether it is offered through or outside of the Marketplace. Selecting this option creates two separate plan variations in the Cost Share Variance worksheet when the worksheet is created: one on-Marketplace plan and one off-Marketplace plan.
Notice Required for Pregnancy	<p>Indicate whether the plan has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if a notice is required. ◆ No—if a notice is <u>not</u> required.
Is a Referral Required for a Specialist? #	<p>Indicate whether a referral is required to see a specialist. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if a referral is required to see a specialist. ◆ No—if a referral is <u>not</u> required to see a specialist.
Specialist(s) Requiring a Referral #	<p>(Required if “Yes” is entered for <i>Is a Referral Required for a Specialist?</i>). Enter the types of specialists that require a referral.</p>
Plan Level Exclusions*	<p>Enter any plan exclusions.</p>

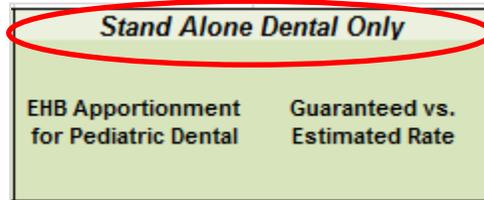
Plan Attributes	Steps
Limited Cost Sharing Plan Variation—Est Advance Payment	This data element is not necessary this year because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Marketplaces will calculate the advance payment amounts for CSRs for limited cost sharing plan variations. Therefore, leave this field blank.
Does this plan offer Composite Rating?	<p>The ability for issuers and employers to use the composite premium field to indicate whether the plans' premiums will be available based on the average enrollee premium amounts has been deferred for 2018. Please leave the field populated to "No."</p> <ul style="list-style-type: none"> ◆ Yes—if the plan offers composite rating. (For 2018, do not select this option.) ◆ No—if the plan does <u>not</u> offer composite rating.
Child-Only Offering *	<p>Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (offered only to individuals who, as of the beginning of the plan year, have not attained the age of 21 for QHP and 19 for SADP); one option must be selected consistent with the requirements at 45 CFR 156.200. This does not apply if the plan's level of coverage is catastrophic.</p> <p>Please note that FF-SHOP and the State Partnership SHOP (SP-SHOP) do not accommodate child-only plans for both medical and SADPs. Enrollment in FF-SHOP and SP-SHOP must include an employee enrollment.</p> <p>Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Allows Adult and Child-Only—if the plan allows adult and child-only enrollment and is offered at a child-only rate. ◆ Allows Adult-Only—if the plan does <u>not</u> allow child-only enrollment. This does not mean that only adults can enroll but that these plans require an adult as the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Since child-only plans are required if "Allows Adult-Only" is selected, as a work-around for FF-SHOP and SP-SHOP plans, issuers should designate these plans as "Allows Adult and Child-Only" and note in the <i>Plan Level Exclusions</i> field that the plan excludes child-only enrollment. (Does not apply to SADPs because they must have the option of being offered to child-only subscribers. Do not select this option unless the SADP is offered in the FF-SHOP or SP-SHOP.) ◆ Allows Child-Only—if the plan is a child-only plan that allows only child subscribers. (Do not select this option for SADP plans offered in the FF-SHOP and SP SHOP.)
Child-Only Plan ID	(Required if "Allows Adult-Only" is entered for <i>Child-Only Offering</i> for plans that are not catastrophic). Enter the corresponding 14-character Plan ID if this plan does <u>not</u> allow child-only enrollment. The entered Plan ID must correspond to a plan in which <i>Child-Only Offering</i> is equal to "Allows Adult and Child-Only" or "Allows Child-Only." The corresponding plan must have the same <i>Level of Coverage</i> as the plan for which the issuer is entering data.
Tobacco Wellness Program Offered	<p>Indicate whether, as required to rate for tobacco use in the small group market, the plan offers a wellness program designed to prevent or reduce tobacco use that meets the standards of Section 2705 of the Public Health Service (PHS) Act. (This is unrelated to whether the plan provides benefits for recommended preventive services, including tobacco use counseling and interventions, under Section 2713 of the PHS Act.) Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. ◆ No—if the plan does <u>not</u> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter No if either of the following applies: <ul style="list-style-type: none"> ▪ The plan is offered in the individual market, or ▪ The plan is offered in the small group market and does not rate for tobacco use.

<i>Plan Attributes</i>	<i>Steps</i>
Disease Management Programs Offered [#]	<p>Indicate whether the plan offers disease management programs. Choose one or more of the following options:</p> <ul style="list-style-type: none"> ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure & High Cholesterol ◆ Low Back Pain ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs
EHB Percent of Total Premium	<p>Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). This is required for all plans on the individual and SHOP markets except for catastrophic plans. This value will be used to calculate advanced premium tax credits and is required to match the value entered in the Unified Rate Review Template (URRT), except for catastrophic plans. For detailed instructions for completing this field, refer to the URRT instructions.</p> <p>Please note that if abortion services are included in the benefits package of the EHB benchmark plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below:</p> <ul style="list-style-type: none"> ◆ If the plan is a QHP offered in the FFM or SBM, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Because subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion. ◆ If the plan is not a QHP offered in the FFM or SBM, but rather is only offered in the outside market, the percentage of the premium associated with abortion services should be included in the EHB percentage. <p>If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state-mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Marketplace.</p>

4.4 Stand-Alone Dental Only

The fields in this section apply to SADPs only (Figure D-5).

Figure 2D-5. SADPs Only Fields



<i>Stand-Alone Dental Only</i>	<i>Steps</i>
EHB Apportionment for Pediatric Dental *	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age banded, use the EHB percent that applies to the pediatric rates. If the rates are family tiered, use the EHB percent of the individual rate assuming a child enrollment. This percentage is used to determine the amount of the advance payment of the premium tax credit required under 45 CFR 155.340(e)(2). Issuers must also submit the “Stand-Alone Dental Plans—Description of EHB Allocation” form as a supporting document.
Guaranteed vs. Estimated Rate *	<p>This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the Rates Table and the Business Rules Template. By indicating the rate is a “Guaranteed Rate,” the issuer commits to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers’ geographic location, age, and other permissible rating factors provided for in the Rates Table and Business Rules Templates. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported. Please note that FF-SHOP and SP-SHOP SADPs offered on the Marketplace does not accommodate estimated rates, and they must have guaranteed rates in order to be offered on the Marketplace.</p> <p>Select whether this plan offers guaranteed or estimated rates:</p> <ul style="list-style-type: none"> ◆ Guaranteed Rate—if the plan offers a guaranteed rate. ◆ Estimated Rate—if the plan offers an estimated rate.

4.5 Plan Dates

This section contains fields for the effective date and expiration date for each plan. The FFM and FF-SHOP rating engine uses the effective dates in the Rates Table Template, not the Plans & Benefits Template (Figure 2D-6).

Figure 2D-6. Plan Dates



Plan Dates	Steps
Plan Effective Date *	This should be the effective date for the upcoming 2018 plan year—even for existing plans offered on-Marketplace in 2017. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2018, for all plans that will be offered through the FFM and FF-SHOP.
Plan Expiration Date *	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (it must be December 31, 2018, for the individual market). In the context of FF-SHOP, the plan is effective for a 12-month plan year. The plan expiration date is 12 months after the original employer coverage effective date.

4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Issuers should only select **Yes** for these data elements if the plan offers the entire package of benefits for the geographic unit. Issuers should not select **Yes** if the plan covers only emergency services for the geographic unit (Figure 2D-7).

Figure 2D-7. Geographic Coverage Fields



Geographic Coverage	Steps
Out of Country Coverage *	Indicate whether care obtained outside the country is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained out of the country. ◆ No—if the plan does <u>not</u> cover care obtained out of the country.
Out of Country Coverage Description *	(Required if “Yes” is selected for <i>Out of Country Coverage</i>). Enter a short description of the care obtained outside the country that the plan covers.
Out of Service Area Coverage *	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained outside the plan service area. ◆ No—if the plan does <u>not</u> cover care obtained outside the plan service area.
Out of Service Area Coverage Description *	(Required if “Yes” is entered for <i>Out of Service Area Coverage</i>). Enter a short description of the care obtained outside the service area that is covered under the plan.
National Network **	Indicate whether a national network is available. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if a national network is available. ◆ No—if a national network is <u>not</u> available.

4.7 URLs

This section contains a field pertaining to URL information on plans (Figure 2D-8).

Figure 2D-8. URL Fields



URLs	Steps
URL for Enrollment Payment*	Enter the website location for enrollment payment information. Only submit a URL if it is a working payment site capable of collecting a consumer's first-month premium and it complies with the latest payment redirect business service description. URLs must start with "http://" or "https://" to work properly for the consumer. This is optional for SADPs.

4.8 Benefit Information

After completing the sections of the template discussed above, issuers will complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans (Figure 2D-9).

Figure 2D-9. Benefits Information Template

<i>Benefit Information</i>				
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
Primary Care Visit to Treat an Injury or Illness				
Specialist Visit				
Other Practitioner Office Visit (Nurse, Physician Assistant)				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				
Outpatient Surgery Physician/Surgical Services				
Hospice Services				
Routine Dental Services (Adult)				
Infertility Treatment				
Long-Term/Custodial Nursing Home Care				
Private-Duty Nursing				

Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. If this benefits package has multi-state plans using an alternate benchmark, click **Yes** to the pop-up. Otherwise, click **No**. The Plans & Benefits Add-In file has been updated to accurately reflect the current EHB benchmark data. Scroll down the worksheet to the Benefit Information section. The following fields may auto-populate, depending on the state, market type, and EHB benchmark:

- ◆ EHB
- ◆ Is this Benefit Covered?
- ◆ Quantitative Limit on Service
- ◆ Limit Quantity
- ◆ Limit Unit
- ◆ Exclusions
- ◆ Benefit Explanation

To add a benefit not listed on the template, click the **Add Benefit** button on the menu bar under the **Plans & Benefits** ribbon.

- ◆ Look through the drop-down menu to see whether the benefit already exists as an option, and select it if it does. If the benefit is not on this menu, click the **Custom** button and type in the benefit name. The benefit name may not be identical to any other benefit's name.
- ◆ A row for this benefit then appears below the last row in the Benefit Information section.
- ◆ If a benefit is mistakenly added, it cannot be deleted, but an issuer may do one of the following:
 - Select **Not Covered** under the *Is this Benefit Covered?* column (described below).
 - Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. This deletes the added benefit, but the issuer also loses any other data entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.
- ◆ If the benefit added is not found in the state's benchmark, and the issuer is not substituting for an EHB found in the state's benchmark, select **Not EHB** as the *EHB Variance Reason*.
- ◆ If the benefit added is not found in the state's benchmark, but the issuer is substituting for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the *EHB Variance Reason*.
- ◆ If the benefit added is a state-required benefit enacted after December 2011, select **Not EHB** as the *EHB Variance Reason*.
- ◆ For more information on how to select the correct EHB Variance Reason, see Section 5.6.
- ◆ A benefits package should not have multiple benefits with identical names. In the event of multiple cost sharing schemas for a given benefit based on multiple limits, choose the cost sharing type that applies to the limits in *Limit Quantity* and *Limit Unit* for each of the network types.

4.9 General Information

This section contains fields that give more information on each benefit in the benefits package, such as whether it is covered, whether it has any limits, and any applicable exclusions or benefit explanations (Figure 2D-10).

Figure 2D-10. General Information Fields

Benefit Information		General Information						
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
Primary Care Visit to Treat an Injury or Illness								
Specialist Visit								
Other Practitioner Office Visit (Nurse, Physician Assistant)								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services								

General Information	Steps
EHB *	<p>This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. Issuers cannot edit this field.</p> <p>Note: Issuers should carefully review the benefits covered by their applicable EHB benchmark plan as identified on CMS's "Information on Essential Health Benefits (EHB) Benchmark Plans" webpage at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html. On the basis of their review of the applicable EHB benchmark plan documents, issuers may need to update the Benefits Package worksheet with any changes required to accurately reflect their coverage of EHB benchmark benefits. See the <i>EHB Variance Reason</i> field instructions below for more information on updating the Benefit Package worksheet.</p>

General Information	Steps
Is this Benefit Covered? *	<p>This field is auto-populated with Covered for benefits identified in the template as EHB. If the <i>Is this Benefit Covered?</i> data element is changed to Not Covered, the issuer must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see the <i>EHB Variance Reason</i> data field and Supporting Document section). If a benefit is marked as Not Covered, it does not appear on the Cost Share Variances worksheet and the remaining fields for this benefit may be left blank. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Covered—if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar coverage or in combination with a cost sharing mechanism (e.g., copays, coinsurance, or deductibles). ◆ Not Covered—if this benefit is <u>not</u> covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service? *	<p>(Required if Covered is entered for <i>Is this Benefit Covered?</i>). This field is auto-populated for benefits identified in the template as EHBs. If this data element is changed, an EHB variance reason must be provided and associated supporting documents. For any benefits not identified as EHBs, choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if this benefit has quantitative limits. ◆ No—if this benefit does <u>not</u> have quantitative limits. <p>Note: Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2017, issuers may not impose combined limits on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Plans & Benefits Template Benefit Package worksheet, issuers must provide a separate limit for those benefits.</p>
Limit Quantity **	<p>(Required if Yes is entered for <i>Quantitative Limit on Service?</i>). This field is auto-populated for benefits in the template identified as EHBs. If the issuer changes this data element, it must provide an <i>EHB Variance Reason</i>. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., a limit of two specialist visits per year, enter “2” here).</p>
Limit Unit **	<p>(Required if Yes is entered for <i>Quantitative Limit on Service?</i>). This field is auto-populated for benefits in the template identified as EHBs. If data are changed for this element, select the <i>EHB Variance Reason</i> of Substantially Equal. For any benefits not identified as EHBs, using the drop-down menus, enter the units being restricted per interval to show the quantitative limits that are placed on this benefit (e.g., if the plans have a limit of two specialist visits per year, enter Visits per year here). Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year ◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits

General Information	Steps
	<ul style="list-style-type: none"> ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. <p>If a benefit has limit units that do not align with the list above, the limit does not auto-populate in the <i>Limit Unit</i> field but does auto-populate in the <i>Benefit Explanation</i> field (e.g., a limit of one hearing aid per ear every 48 months for subscribers up to age 18).</p> <p>If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB benchmarks on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). The message “Quantitative limit units apply, see EHB benchmark” appears in the <i>Benefit Explanation</i> field (e.g., Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services).</p> <p>If a benefit has multiple limit units, they do not auto-populate. Put the limit quantity and limit unit that should be displayed on the Plan Compare function of the FFM website in these columns, and put all other quantitative limits in the <i>Benefit Explanation</i> field (e.g., Outpatient Rehabilitative Services—90 days per year in the <i>Limit Quantity</i> and <i>Limit Unit</i> columns; two treatments per year in the benefit explanation).</p> <p>The message “Quantitative limit units apply, see EHB benchmark” may appear in the <i>Benefit Explanation</i> field for a benefit that does not have quantitative limits in the “Benefits and Limits” section of the EHB benchmark on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). This message appears because certain benefits, identified in the <i>Other Benefits</i> section of the EHB benchmark Benefit Template, may have quantitative limits, which may not apply to all services in the higher-level benefit category.</p>
Exclusions **	<p>Enter any benefit-level exclusions.</p> <ul style="list-style-type: none"> ◆ If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions. ◆ If <u>no</u> services or diagnoses are excluded, leave this field blank.
Benefit Explanation **	<p>Enter any benefit explanations.</p> <ul style="list-style-type: none"> ◆ Examples of benefit explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed descriptions of services provided, and alternate cost-sharing structures if they depend on provider type or place of service.
EHB Variance Reason *	<p>(Required if the issuer changed the fields <i>Is this Benefit Covered?</i>, <i>Limit Units</i>, or <i>Limit Quantity</i> or if the benchmark has an unallowable limit or exclusion under the ACA). Select from the following <i>EHB Variance Reasons</i> if this benefit differs from the state’s benchmark:</p> <ul style="list-style-type: none"> ◆ Not EHB—if this benefit is <u>not</u> an EHB.

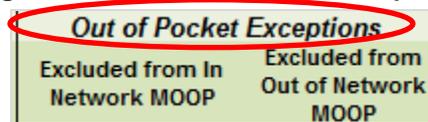
General Information	Steps
	<ul style="list-style-type: none"> ▪ If the issuer has added a new benefit and it is not found in the state's benchmark, the <i>EHB</i> field will be blank and the issuer should set the <i>EHB Variance Reason</i> to Not EHB. This benefit is <u>not</u> considered an EHB. ▪ If a benefit auto-populated as Yes in the <i>EHB</i> column, but the issuer has received guidance from CMS or the state indicating that it should not be considered an EHB, set the <i>EHB Variance Reason</i> to Not EHB. This benefit is <u>not</u> considered an EHB. <ul style="list-style-type: none"> ◆ Substituted—if a benefit is included in the state's benchmark, the <i>EHB</i> field auto-populates as Yes. If substituting a different benefit for an EHB, set the <i>EHB Variance Reason</i> field to Substituted and the <i>Is this Benefit Covered?</i> field to Not Covered. The benefit that takes its place must be designated as Additional EHB Benefit, and the issuer must provide the “EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification” document to support the actuarial equivalence of the substitution. ◆ Substantially Equal—if the <i>Limit Quantity</i> for a benefit differs from the limit quantity in the EHB benchmark, but is still substantially equal to the EHB benchmark, select Substantially Equal as the <i>Variance Reason</i>. Also, if the <i>Limit Unit</i> for a benefit differs from the limit unit in the EHB benchmark, but is still substantially equal to the EHB benchmark, select Substantially Equal as the <i>Variance Reason</i>. For example, if the benchmark lists a limit of 40 hours per month, and the plan defines a day as 8 hours and lists a limit of 5 days per month, the issuer should use that variance reason. ◆ Using Alternate Benchmark—multi-state plans use an alternate benchmark. Issuers should select this EHB variance reason for any benefit that has Yes for EHB but is not an EHB in the alternate benchmark. ◆ Other Law/Regulation—if a benefit is required by a state or federal law or regulation that was enacted on or before December 31, 2011, and the benefit is not represented in the state's EHB benchmark plan. (State-required benefits that were enacted after December 31, 2011, are <u>not</u> EHBs, and for those the issuer should use Not EHB as the variance reason instead.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan and coverage is only state-required in the individual market. When an issuer is filling out the template for an individual market plan, coverage of the benefit must be changed from blank to Covered using the EHB variance reason “Other Law/Regulation.” ◆ Additional EHB Benefit—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are. In this case, change the benefit to Covered, and choose Additional EHB Benefit as the EHB variance reason. This benefit is considered an EHB, and cost sharing values for the plan variations should be entered accordingly. ◆ Dental Only Plan Available—if a dental benefit auto-populates as Covered, but the issuer is not covering a benefit because it is a dental EHB covered by a separate dental only plan, set the <i>EHB Variance Reason</i> to Dental Only Plan Available. For example, an issuer may offer SADPs to cover pediatric dental benefits, so they will not need to cover pediatric dental as part of the medical plans. The issuer would select Not Covered and select Dental Only Plan Available as the EHB variance reason for benefits, such as <i>Dental Check-Up for Children</i>, <i>Basic Dental Care—Child</i>, <i>Orthodontia—Child</i>, and <i>Major Dental Care—Child</i> if the benefits are designated as a Covered EHB. (This option is not applicable to SADPs) <p>Note: Because EHB benchmark plan benefits are based on plans that were sold in 2012 or 2014, some of the benchmark plan designs may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Therefore, issuers should carefully review the information available on the CMS</p>

General Information	Steps
	<p>“Information on Essential Health Benefits (EHB) Benchmark Plans” webpage (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html).</p> <p>If more than one EHB variance reason applies, select the option related to EHB designation instead of the one related to limits. For example, if an issuer adds a new benefit that is an EHB and also changes its limits, the EHB variance reason that should be selected is “Additional EHB Benefit” instead of “Substantially Equal.” It is important that the issuer enter the correct <i>EHB Variance Reason</i> because it has implications for nondiscrimination and EHB reviews as well as cost sharing requirements for EHBs and non-EHBs related to cost sharing reduction plan variations.</p>

4.10 Out-of-Pocket Exceptions

This section is for indicating whether each benefit is excluded from the MOOP. All plans in a benefits package must have the same MOOP structure and exclude the same benefits from the MOOP. To create plans with a different MOOP structure, issuers must create a new benefits package and then a new Cost Share Variances worksheet (Figure 2D-11).

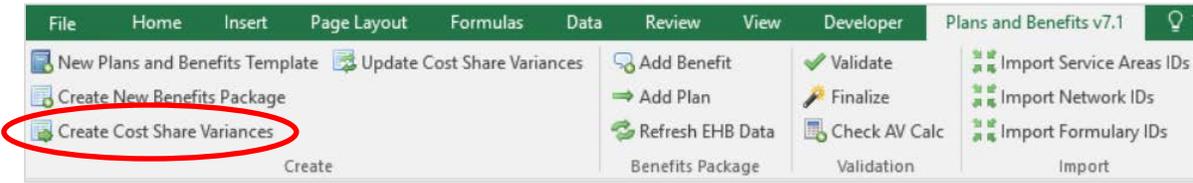
Figure 2D-11. Out of Pocket Exceptions



Out-of-Pocket Exceptions	Steps
Excluded from In-Network MOOP *	<p>Indicate whether this benefit is excluded from the in-network MOOP. Only benefits not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if this benefit is excluded from the in-network MOOP. ◆ No—if this benefit is <u>not</u> excluded from the in-network MOOP.
Excluded from Out-of-Network MOOP *	<p>Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if this benefit is excluded from the out-of-network MOOP. ◆ No—if this benefit is <u>not</u> excluded from the out-of-network MOOP.
<ul style="list-style-type: none"> ◆ If the plans only have a combined (no separate in-network) MOOP, set <i>Excluded from In Network MOOP</i> equal to <i>Excluded from Out of Network MOOP</i>. ◆ If <i>Is this Benefit Covered?</i> for a benefit is Not Covered, or blank, leave <i>Excluded from In Network MOOP</i> and <i>Excluded from Out of Network MOOP</i> blank. ◆ If the plans do not have an out-of-network MOOP, set <i>Excluded from Out of Network MOOP</i> equal to Yes. 	

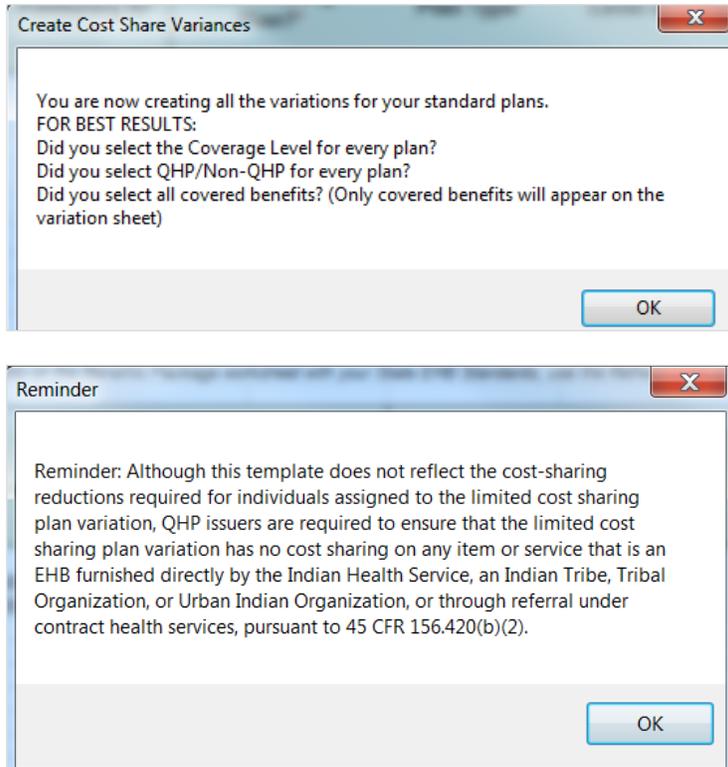
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-12). The Cost Share Variances worksheet is designed to collect more detailed cost sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2D-12. Create Cost Share Variances Button



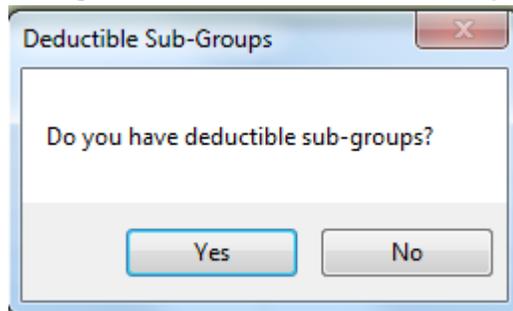
Click **OK** after reading the warnings (Figure 2D-13), and make any necessary changes.

Figure 2D-13. Warning Pop-Up Boxes



The following questions pop up regarding deductible sub-groups (Figure 2D-14). Deductible sub-groups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible sub-groups are not separate deductibles outside any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible sub-groups.

Figure 2D-14. Deductible Sub-Groups



1. Do you have any deductible sub-groups?
 - a. **Yes**—if the plan contains deductible sub-groups.
 - b. **No**—if the plan does not contain deductible sub-groups.
2. How many deductible sub-groups do you have? Enter the correct number, and click **OK**.
3. What is the name of this deductible sub-group? Enter the name of each sub-group, and click **OK** after each. You must use a different name for each sub-group.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (Figure 2D-15). Corresponding worksheets are labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 2D-15. Cost Share Variances Worksheet

Plan Cost Sharing Attributes										
HIOS Plan ID* (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?	Medical & Drug Maximum Out of Pocket Integrated?*	Multiple In Network Tiers?	1st Tier Utilization*	2nd Tier Utilization*

For details on updating the Cost Share Variances worksheet after it has been created and incorporating changes made to the Benefits Package worksheet, see Section 5.4.

4.11 Plan Cost-Sharing Attributes

This section has fields with basic information on each plan and cost sharing reduction plan variation, such as its Plan ID, marketing name, and metal level. It also asks questions about the medical and drug integration for deductibles and MOOP to determine the appropriate columns to fill out later in the template.

Note: The Cost Share Variances worksheet is designed to collect more detailed cost sharing benefit design information for all plans and plan variations submitted by the issuer. However, cost-sharing reductions do not apply to SADPs.

Plan Cost Sharing Attributes	Steps
HIOS Plan ID *	<p>The HIOS-generated number auto-populates for each cost sharing plan variation.</p> <ul style="list-style-type: none"> ◆ Standard plans to be offered on the Marketplace have a Plan ID variant suffix of “-01,” and standard plans to be offered outside the Marketplace have a Plan ID variant suffix of “-00.” ◆ For the individual market, each standard plan (except for catastrophic) has two cost sharing reduction plan variations for American Indians and Alaska Natives: one with zero cost sharing and one with limited cost sharing. These are indicated with a Plan ID variant suffix of “-02” and “-03,” respectively. <ul style="list-style-type: none"> ▪ In the zero cost sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs. ▪ In the limited cost sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian health care provider or from another provider if they have a referral from an Indian health care provider. ◆ Also in the individual market, each silver plan has three additional cost sharing reduction plan variations created: a 73 percent AV plan, an 87 percent AV plan, and a 94 percent AV plan. These are indicated with a Plan ID variant suffix of “-04,” “-05,” and “-06,” respectively. <ul style="list-style-type: none"> ▪ These silver plan variations offer a discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments, and there is also a lower MOOP. Consumers qualify for these plans if their income is below a certain level.
Plan Variant Marketing Name **	<p>The name of the plan auto-populates for all standard plans and plan variations with the standard plan’s plan marketing name. The field can be edited on this worksheet for each of the plan variations. The marketing name entered for each plan variation on this worksheet will be the one that displays to consumers. The field has a limit of 255 characters.</p>
Level of Coverage ^*	<p>The coverage level for the plan auto-populates for standard plans.</p>
CSR Variation Type ^	<p>The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, a standard off-Exchange plan, or one of the cost sharing reduction plan variations explained in this section.</p>
Issuer Actuarial Value *	<p>(Required if Yes is entered for <i>Unique Plan Design</i>). Enter the issuer-calculated AV. This applies to health plans that indicate they are a unique plan for AV purposes and SADP. SADP issuers must submit the “Stand-Alone Dental Plan Actuarial Value” supporting documentation certifying that their actuarial value was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methods.</p>
AV Calculator Output Number	<p>Clicking the Check AV Calc button on the Plans & Benefits ribbon and selecting the correct file populates this field with the AV for all plans on this worksheet with a non-unique plan design. All cost sharing information and benefits package information must be filled in before clicking this button. (For more information, see Appendix 1.)</p>
Medical & Drug Deductibles Integrated? ^	<p>Indicate whether the medical and drug deductible is integrated. An integrated deductible means that both medical and drug charges contribute to a total plan-level deductible. A separate deductible means medical and drug charges contribute to separate plan-level deductibles. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the medical and drug deductible is integrated. If Yes is entered, issuers should not enter information in the following sections: <i>Medical Deductible</i> and <i>Drug Benefits Deductible</i>. ◆ No—if the medical and drug deductible is <u>not</u> integrated. If No is entered, issuers should not enter information in the following section: <i>Combined Medical & Drug Deductible</i>.

Plan Cost Sharing Attributes	Steps
Medical & Drug Maximum Out of Pocket Integrated? ^	<p>Indicate whether the medical and drug MOOP is integrated. An integrated MOOP means that both medical and drug charges contribute to a total plan-level MOOP. A separate MOOP means medical and drug charges contribute to separate plan-level MOOP values. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the medical and drug MOOP is integrated. If Yes is entered, issuers should not enter information in the following sections: <i>Maximum Out of Pocket for EHB Benefits</i> and <i>Maximum Out of Pocket for Drug Benefits</i>. ◆ No—if the medical and drug deductible MOOP is <u>not</u> integrated. If No is entered, issuers should not enter information in <i>Maximum Out of Pocket for EHB and Drug Benefits (Total)</i>.
Multiple In Network Tiers? ^*	<p>Indicate whether there are multiple in-network provider tiers, meaning that the plan applies to different levels of in-network cost sharing depending on the tier of the provider or facility. The value must be the same for all variations of a plan. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if there are multiple in-network provider tiers. Enter Tier 1 information into the <i>In Network</i> and <i>In Network (Tier 1)</i> sections and Tier 2 information into the <i>In Network (Tier 2)</i> sections. ◆ No—if there are not multiple in-network provider tiers. Issuers will not be able to enter information into the <i>In Network (Tier 2)</i> sections, which will be grayed out and locked for editing.
1st Tier Utilization ^*	<p>If the answer to <i>Multiple In Network Tiers?</i> is Yes, enter the <i>1st Tier Utilization</i> as a percentage here. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. If the answer to <i>Multiple In Network Tiers?</i> is No, the field auto-populates to “100%.” (All plan variations must have the same 1st tier utilization as the standard plan.)</p>
2nd Tier Utilization ^*	<p>If the answer to <i>Multiple In Network Tiers?</i> is Yes, enter the <i>2nd Tier Utilization</i> as a percentage here. This cell will be grayed out and locked for editing if the answer to <i>Multiple In-Network Tiers?</i> is No. (All plan variations have the same 2nd tier utilization as the standard plan.)</p>

4.12 Summary of Benefits and Coverage (SBC) Scenario

This section contains fields for basic information on three Summary of Benefits and Coverage (SBC) scenarios. This section is not applicable to SADPs. Additional information containing SBC scenario coverage examples and further resources for completing the scenarios can be found in the Summary of Benefits and Coverage and Uniform Glossary section of the website at <http://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index.html>. Any other concerns or technical assistance inquiries about these fields can be directed to sbc@cms.hhs.gov. Fill out the following data fields for all three coverage examples (*Having a Baby*, *Having Diabetes*, and *Treatment of a Simple Fracture*).

Plan Cost Sharing Attributes	Steps
Deductible #	Enter the numerical value for the deductible.
Copayment #	Enter the numerical value for the copayment.
Coinsurance #	Enter the numerical value for the coinsurance.
Limit #	Enter the numerical value for the benefit limits or exclusion amount.

4.13 Maximum Out-of-Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Not all of the sections should be filled out, depending on whether the medical and drug MOOP and deductibles are integrated, as indicated through the entries in the fields *Medical & Drug Deductibles Out of Pocket Integrated?*

and *Medical & Drug Maximum Out of Pocket Integrated?*. SADP issuers should skip to Sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (For guidance filling out the MOOP and Deductible sections of the template, and ensuring that all requirements are met, see Section 5.1.)

As of PY2016, the *Family* fields for *In Network*, *In Network (Tier 2)*, and *Out of Network* MOOP and deductibles will have additional options. When selecting these fields, a pop-up will appear allowing the issuer to enter a per-group amount and a per-person amount. The per-group amount is the total MOOP or deductible limit when accruing costs for all members in a family (i.e., any coverage other than self-only). The per-person amount is the MOOP or deductible limit that applies separately to each person in a family. The *Per Person* and *Per Group* fields will be displayed to consumers on Plan Compare when they are shopping for coverage with more than one person in the enrollment group. The following requirements apply to this new field:

- ◆ The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan (\$7,350) and for the specific cost sharing reduction plan variations. See Section 5.5 for more details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.
- ◆ There must be a per-person amount and per-group amount entered for MOOP; the issuer may not enter **Not Applicable** for all these cells in all *Family* fields. The only exception is if a given plan is available to consumers only as self-only coverage.

4.14 Maximum Out-of-Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in Figure 2D-16.

Figure 2D-16. MOOP Fields

Maximum Out of Pocket for Medical EHB Benefits							
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network	
Individual	Family	Individual	Family	Individual	Family	Individual	Family

This section is used for inputting MOOP values for medical EHB benefits and is required only if the medical and drug MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for EHB benefits in the following areas of the template.

MOOP Medical EHB Benefits	Steps
In Network—Individual ^{^#}	If MOOPs are <u>not</u> integrated, enter the dollar amount for Medical In Network Individual Maximum Out of Pocket for EHB Benefits.
In Network—Family ^{^#}	If MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for Medical In Network Family Maximum Out of Pocket for EHB Benefits.
In Network (Tier 2)—Individual [^]	If MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for Medical In Network (Tier 2) Individual Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and cannot be edited.
In Network (Tier 2)—Family	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for Medical In Network (Tier 2) Family Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If MOOPs are <u>not</u> integrated, enter the dollar amount for Medical Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Out of Network—Family	If MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for Medical Out of Network Family Maximum Out of Pocket for EHB Benefits.

MOOP Medical EHB Benefits	Steps
Combined In/Out Network—Individual ^#	If MOOPs are <u>not</u> integrated, enter the dollar amount for Medical Combined In/Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Combined In/Out Network—Family #	If MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for Medical Combined In/Out of Network Family Maximum Out of Pocket for EHB Benefits.

4.15 Maximum Out-of-Pocket for Drug EHB Benefits

This section is used for inputting MOOP values for drug EHB benefits and is required only if the medical and drug MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for drug EHB benefits in the following areas of the template.

MOOP Drug EHB Benefits	Steps
In Network—Individual ^#	If MOOPs are not integrated, enter the dollar amount for In Network Individual Maximum Out of Pocket for Drug EHB Benefits.
In Network—Family #	If MOOPs are not integrated, enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for Drug EHB Benefits.
In Network (Tier 2)—Individual ^	If MOOPs are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the <i>In Network—Individual</i> field.)
In Network (Tier 2)—Family	If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the <i>In Network—Family</i> field.)
Out of Network—Individual	If MOOPs are not integrated, enter the dollar amount for Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Out of Network—Family	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Individual ^#	If MOOPs are not integrated, enter the Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Family #	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.

4.16 Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)

This section is used for inputting MOOP values for medical and drug EHB benefits, and is required only if the medical and drug MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the

drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for medical and drug EHB benefits in the following areas on the template.

MOOP Medical & Drug EHB Benefits	Steps
In Network—Individual ^{^#}	If MOOPs are integrated, enter the dollar amount for the Total In Network Individual Maximum Out of Pocket.
In Network—Family [#]	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total In Network Family Maximum Out of Pocket.
In Network (Tier 2)—Individual [^]	If MOOPs are integrated and the plan has multiple in-network tiers, enter the dollar amount for the Total In Network (Tier 2) Individual Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for the Total In Network (Tier 2) Family Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If MOOPs are integrated, enter the dollar amount for the Total Out of Network Individual Maximum Out of Pocket.
Out of Network—Family	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Out of Network Family Maximum Out of Pocket.
Combined In/Out Network—Individual ^{^#}	If MOOPs are integrated, enter the dollar amount for the Total Combined In/Out of Network Individual Maximum Out of Pocket.
Combined In/Out Network—Family [#]	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Combined In/Out of Network Family Maximum Out of Pocket.

4.17 Medical EHB Deductible

This section is used for inputting deductible values for medical EHB benefits and is required only if the medical and drug deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for EHB benefits in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual ^{^#}	If deductibles are not integrated, enter the dollar amount for In Network Individual Medical EHB Deductible.
In Network—Family [#]	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Medical EHB Deductible.
In Network—Default Coinsurance [^]	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. Note: If deductibles are not integrated, this is a required field for the AV calculation for those plans using the AVC.
In Network (Tier 2)—Individual [^]	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.

Medical EHB Deductible	Steps
In Network (Tier 2)—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Medical Deductible.
Out of Network—Family	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Medical EHB Deductible.
Combined In/Out Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Medical EHB Deductible.
Combined In/Out Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Medical EHB Deductible.

4.18 Drug EHB Deductible

This section is used for inputting deductible values for drug EHB benefits and is required only if the medical and drug deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for drug EHB benefits in the following areas on the template.

Drug EHB Deductible	Steps
In Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for In Network Individual Drug EHB Deductible.
In Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Drug EHB Deductible.
In Network—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual ^	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the <i>In Network—Individual</i> field.)
In Network (Tier 2)—Family	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the <i>In Network—Family</i> field.)
In Network (Tier 2)—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the <i>In Network—Default Coinsurance</i> field.)
Out of Network—Individual	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Drug EHB Deductible.
Out of Network—Family	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Drug EHB Deductible.

Drug EHB Deductible	Steps
Combined In/Out Network—Individual ^{^#}	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Drug EHB Deductible.
Combined In/Out Network—Family [#]	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Drug EHB Deductible.

4.19 Combined Medical and Drug EHB Deductible

This section is used for inputting deductible values for medical and drug EHB benefits and is required only if the medical and drug deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for medical and drug EHB benefits in the following areas on the template.

Medical & Drug EHB Deductible	Steps
In Network—Individual ^{^#}	If deductibles are integrated, enter the dollar amount for In Network Individual Combined Medical and Drug EHB Deductible.
In Network—Family [#]	If deductibles are integrated, enter the per-person and per-group dollar amount for In Network Family Combined Medical and Drug EHB Deductible.
In Network—Default Coinsurance [^]	If deductibles are integrated, enter the numerical value for the in-network coinsurance. (If deductibles are integrated, this field is required for the AV calculation for plans using the AVC.)
In Network (Tier 2)—Individual [^]	If deductibles are integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Default Coinsurance [^]	If deductibles are integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If deductibles are integrated, enter the dollar amount for Out of Network Individual Combined Medical and Drug EHB Deductible.
Out of Network—Family	If deductibles are integrated, enter the per-person and per-group dollar amount for Out of Network Family Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Individual ^{^#}	If deductibles are integrated, enter the dollar amount for Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Family [#]	If deductibles are integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Combined Medical and Drug EHB Deductible.

4.20 Maximum Out-of-Pocket for Dental EHB Benefits

This section is used for inputting MOOP values for dental EHBs. When entering the MOOP values, ensure that the following limits are met: The MOOP values must be equal to or below the required limits of \$350 for one covered child (considered the “individual” limit) and \$700 for two or more covered children (considered the “family” limit). To include multiple children in child-only plans, use the “family” fields. (For SADPs, an individual is considered one child and a family is considered two or more children.) Using the drop-down menus, enter the

appropriate values for the *Individual* and *Family* MOOP for EHB dental benefits in the following areas of the template.

MOOP Dental EHB Benefits	Steps
In Network—Individual *^#	Enter the dollar amount for Dental In Network Individual MOOP for EHB Benefits.
In Network—Family **	Enter the per-person and per-group dollar amount for Dental In Network Family MOOP for EHB Benefits.
In Network (Tier 2)—Individual *^	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental for EHB Benefits.
In Network (Tier 2)—Family *	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family MOOP for EHB Benefits.
Out of Network—Individual *	Enter the dollar amount for Dental Out of Network Individual MOOP for EHB Benefits.
Out of Network—Family *	Enter the per-person and per-group dollar amount for Dental Out of Network Family MOOP for EHB Benefits.
Combined In/Out Network—Individual *^#	Enter the dollar amount for Dental Combined In/Out of Network Individual MOOP for EHB Benefits.
Combined In/Out Network—Family **	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family MOOP for EHB Benefits.

4.21 Dental EHB Deductible

This section is used for inputting deductible values for dental EHB benefits. The deductible value may not be higher than the MOOP value. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for EHB benefits in the following areas on the template.

Dental EHB Deductible	Steps
In Network—Individual *^#	Enter the dollar amount for Dental In Network Individual Deductible.
In Network—Family **	Enter the per-person and per-group dollar amount for Dental In Network Family Deductible.
In Network—Default Coinsurance *^	Enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual *^	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental Deductible.
In Network (Tier 2)—Family *	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family Deductible.
Out of Network—Individual *	Enter the dollar amount for Dental Out of Network Individual Deductible.
Out of Network—Family *	Enter the per-person and per-group dollar amount for Dental Out of Network Family Deductible.
Combined In/Out Network—Individual *^#	Enter the dollar amount for Dental Combined In/Out of Network Individual Deductible.
Combined In/Out Network—Family **	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family Deductible.

4.22 Other Deductible

Issuers should complete this section if they have deductible sub-groups; they can add an unlimited number of deductible sub-groups and name them. Enter the appropriate values for the *Individual* and *Family* data elements in the following areas on the template. (These values are not separate deductibles outside any maximums allowed, and they still contribute to the MOOP and deductible limits.)

Other Deductible	Steps
In Network— Individual *^#	If deductibles are not integrated, enter the dollar amount for In Network Individual Other Deductible.
In Network—Family *#	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Other Deductible.
In Network Tier 2— Individual *^	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network Tier 2— Family *	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network— Individual *	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Other Deductible.
Out of Network—Family *	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Other Deductible.
Combined In/Out Network—Individual *	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Other Deductible.
Combined In/Out Network—Family *	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Other Deductible.

4.23 Health Savings Account (HSA)/Health Reimbursement Account (HRA) Detail

HSA/HRA Detail	Steps
HSA-Eligible ^{^#}	Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if the plan meets all HSA requirements. ◆ No—if the plan does <u>not</u> meet all HSA requirements.
HSA/HRA Employer Contribution [^]	(Required for small group only; must be left blank for individual market). Indicate whether the employer contributes to an HSA/HRA. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if the plan has an HSA/HRA employer contribution. ◆ No—if the plan does <u>not</u> have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount [^]	(Required if Yes is entered for <i>HSA/HRA Employer Contribution</i> ; must be left blank for individual market). Enter a numerical value representing the employer contribution amount to HSA/HRA. The template does not permit an individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 <i>Federal Register</i> (FR) 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

4.24 URLs

This section contains fields for URLs for applicable websites. URLs must start with “http://” or “https://” to work properly for the consumer. To give consumers access to all relevant plan information needed to compare and select plans, CMS asks that issuers ensure that their URLs link directly to up-to-date and accurate information that is readily obtainable on their websites. Issuers should ensure that prospective enrollees can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

Issuer URLs should link directly to each SBC and each plan brochure, respectively, for the standard plan or plan variation in question. This will provide consumers with the best and most accurate shopping experience when searching for available plans through FFM. Linking directly to the SBCs and plan brochures will guarantee that consumers will see the document that directly applies to the health plan that they are considering for purchase.

As part of the ongoing compliance monitoring, CMS may compare the benefits coverage and cost sharing information inputted in the Plans & Benefits Template with the information issuers provide to consumers on the plan's SBC and plan brochure. Please take care to review the information submitted on this template, as well as what coverage is represented on the plan's SBC and the plan brochure to ensure that all of this information is aligned with the actual terms of coverage before submission.

URLs	Steps
URL for Summary of Benefits & Coverage [#]	Enter the URL that takes the consumer directly to the SBC content for the specific standard plan or plan variation. As defined in 45 CFR 155.205(b)(1)(ii), plans will <u>not</u> be displayed to consumers if this field is not completed.
Plan Brochure #	<ul style="list-style-type: none"> ◆ Enter the URL that goes directly to the plan brochure for the specific standard plan or plan variation. These documents 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. ◆ CMS expects that issuers submit SBC and plan brochure URLs by the final deadline for submission of QHP data so that the FFM can meet its responsibility to provide

URLs	Steps
	consumer's access to the appropriate SBCs through its website (see 45 CFR 155.205). CMS expects these links to be active and directly route the user to the appropriate document by the time the issuer has signed its QHP agreements. Issuers are strongly encouraged to submit these links and make them active earlier so that they can fully test their data through Plan Preview.

4.25 AV Calculator Additional Benefit Design

This section contains optional fields, which may be filled out for use as inputs in the AVC.

URLs	Steps
Maximum Coinsurance for Specialty Drugs ^	Indicate whether the per-script coinsurance amount for specialty drugs is capped at a set amount. Enter the maximum coinsurance payments allowed for specialty prescription drugs. If no maximum coinsurance exists, leave the field blank.
Maximum Number of Days for Charging an Inpatient Copay? ^	Indicate whether there is a limit on the number of days that a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day. Enter the maximum number of days allowed (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost-Sharing After a Set Number of Visits? ^	Indicate whether primary care cost sharing begins after a certain number of fully covered visits. Enter the maximum number of fully covered visits (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? ^	Indicate whether primary care visits are subject to the deductible and/or coinsurance after a certain number of primary care visits with copay have occurred. Enter the maximum number of copay visits (1–10) that can occur before visits become subject to the deductible and/or coinsurance. If this option does not apply, leave the field blank.

4.26 Covered Benefits

This section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

Fill in information for each of the benefits as follows:

- If the issuer has plans that do not have out-of-network benefits for a given covered benefit, enter “Not Applicable” for the out-of-network copay fields and “100%” for the out-of-network coinsurance fields.
- As of plan year 2016, there is a drop-down option of “Not Applicable” for all cost sharing fields. This value should be used:
 - If issuer charges only a copay or a coinsurance for a benefit, enter “Not Applicable” for the other. For example, if an issuer wishes to charge a \$20 copay for a benefit, enter “\$20” for the copay and “Not Applicable” for the coinsurance. Please note that “No Charge” was used for this scenario in past years, but “Not Applicable” is the correct option in the 2018 template.
 - If issuer has multiple in-network tiers, for any benefit category that does not have tiers, enter “Not Applicable” for the *In Network (Tier 2)* copay and coinsurance. For example, if the issuer has only multiple in-network tiers for its inpatient hospital covered benefits, it would enter Tier 2 cost sharing as described below. For other covered benefits without multiple in-network tiers, issuers should enter “Not Applicable” for the *In Network (Tier 2)* copay and coinsurance.
- For further instructions on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see Section 5.8.

4. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, please see Appendix 1.
5. There are many cost sharing requirements for the cost sharing reduction silver plan variations and the zero and limited cost sharing plan variations (see Section 5.5).
6. If cost sharing varies on the basis of place of service or provider type, ensure that no benefit already specifically applies to the place of service or provider type. If there is not one available, fill out the copay and/or coinsurance most typical for most enrollees (such as the highest utilized); in the *Benefit Explanation* field, add appropriate and brief detail to communicate the cost sharing in the scenarios other than the most common one already entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) also should clearly communicate any cost sharing information that may vary on the basis of place of service or provider type.

Figure 2D-17 shows an example of how the fields for each benefit are laid out.

Figure 2D-17. Benefit Information Fields

BV	BW	BX	BY	BZ	CA
Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>	<i>In Network (Tier 1)</i>	<i>In Network (Tier 2)</i>	<i>Out of Network</i>
\$0	\$0	\$0	0%	0%	0%

Covered Benefits	Steps
Copay—In Network (Tier 1) *A#	<p>If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter Not Applicable. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 2) *A#	<p>If the plan has multiple in-network tiers and an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter “Not Applicable.” For any benefit category that does not have tiers, enter “Not Applicable” for this field, as well as the field <i>Coinsurance—In Network (Tier 2)</i>. This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged.

Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance, or there are not multiple tiers for this benefit. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—Out of Network ^{##}	<p>If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter Not Applicable. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network	<p>The following options are the only available options for the benefits <i>Inpatient Hospital Services (e.g., Hospital Stay)</i> and <i>Skilled Nursing Facility</i>. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure that all variations follow the same “per day” or “per stay” cost sharing structure. If no copayment is charged, enter Not Applicable.</p> <p>The benefits <i>Mental/Behavioral Health Inpatient Services</i> and <i>Substance Abuse Disorder Inpatient Services</i> include these options as well as those described in the section <i>Copay—In Network (Tier 1)</i> above. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Day—the consumer pays a copayment per day (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay per Stay—the consumer pays a copayment per stay (this indicates that this benefit is <u>not</u> subject to the deductible).

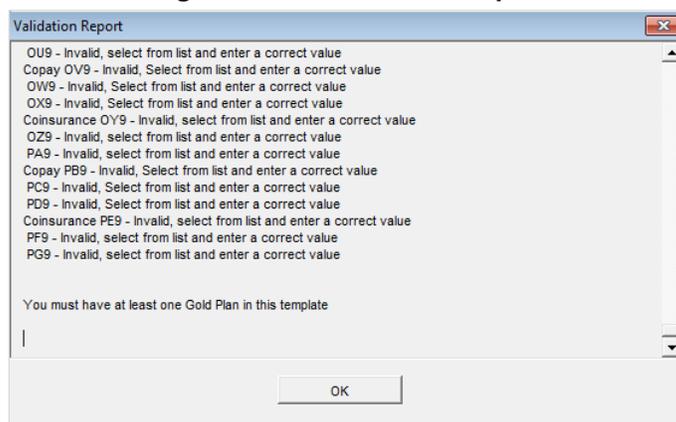
Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ \$X Copay per Day after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Stay after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Day with deductible—the consumer first pays the copay per day, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Stay with deductible—the consumer first pays the copay for the stay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit. <p>For <i>Inpatient Hospital Services (e.g., Hospital Stay)</i> and <i>Skilled Nursing Facility</i> covered benefits, <u>do not</u> copy and paste cost sharing values entered for other benefits (e.g., \$25 copay). The entered values should have the “per day” or “per stay” qualifiers. Copying and pasting any other cost sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.</p>
Coinsurance—In Network (Tier 1) *^#	<p>If an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter Not Applicable, unless the plan has a Tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a copay is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ Not Applicable—the consumer only pays a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—In Network (Tier 2) *^#	<p>If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter Not Applicable, unless the plan has a Tier 2 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” For any benefit category that does not have tiers, enter Not Applicable for this field, as well as for the field <i>Copay—In Network (Tier 2)</i>. This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a copay is charged.

Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ Not Applicable—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network ^{**}	<p>If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If no coinsurance is charged, enter Not Applicable, unless the plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter “0%.” If this benefit is not covered out-of-network, enter “100%.” Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a copay is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ Not Applicable—the consumer pays only a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.27 Completed Plans & Benefits Template

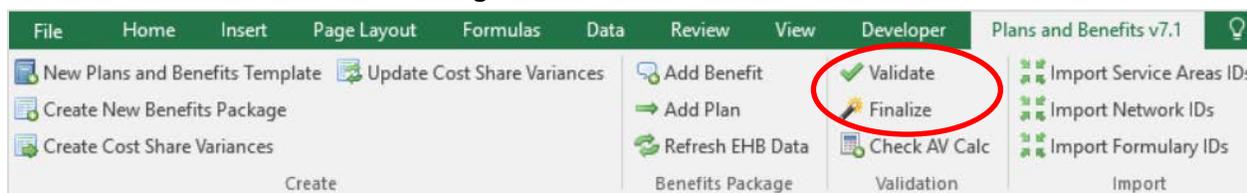
Once the entire template, including all Benefits Package and Cost Sharing Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans & Benefits** ribbon. If there are validation errors, a Validation Report (Figure 2D-18) will appear showing the data element and cell location of each error. The issuer must correct these errors for its Plans & Benefits Template to be accepted.

Figure 2D-18. Validation Report



Once the validation is successful, click the **Finalize** button on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-19) to save the template as an XML file. Upload the saved file in the Benefits and Service Area Module. Before closing the template, save an XLSM version of the Excel file onto the computer for future reference.

Figure 2D-19. Finalize Button



5. Key Requirements and Application Guidance

This section contains guidance and examples for filling out specific sections of the Plans & Benefits Template and describes specific plan requirements. Issuers should read this section to ensure plan compliance.

5.1 MOOP and Deductible Guidance

Several requirements must be met for MOOP and deductible values. Complete the MOOP and deductible sections of the template as follows:

1. Annual Limitation on Cost Sharing.⁷ When entering the MOOP values, ensure that the limits listed below are met for the in-network EHB MOOP. (See the 2018 HHS Notice of Benefit and Payment Parameters for more details on the annual limit values.)
 - a. If the plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.
 - b. The standard plan's in-network EHB MOOP values must be less than or equal to \$7,350 for an individual (self-only) or \$14,700 for a family (other than self-only).
 - c. For the 73 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$5,850 for an individual (self-only) or \$11,700 for a family (other than self-only).
 - d. For the 87 percent and 94 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$2,450 for an individual (self-only) or \$4,900 for a family (other than self-only).

⁷ See the rule on the HHS Notice of Benefit and Payment Parameters for 2018 (81 FR 94058; December 22, 2016). Issuers must comply with policies that are incorporated into the final rule on the HHS Notice of Benefit and Payment Parameters for 2018.

- e. For the zero cost sharing plan variations, in- and out-of-network MOOP and deductible values for EHB must be \$0. These fields auto-populate and should not be changed for EHB.
 - f. For the limited cost sharing plan variations, the MOOP and deductible values must be the same as the associated standard plan's EHB MOOP value. These fields auto-populate whenever a value is entered for a standard plan and should not be changed.
2. Family MOOP Requirements. When entering the MOOP values, ensure that the limits listed below are taken into consideration. (See the 2018 HHS Notice of Benefit and Payment Parameters for more details on the annual limit on cost sharing.)
 - a. Plans that allow multi-member enrollment (family plans) must have a numeric value for either in-network or combined in- and out-of-network MOOP for both per group and per person. These plans are subject to the annual limitation on cost sharing for other than self-only coverage (\$14,700) discussed above, as well as the annual limitation on cost sharing for self-only coverage.
 - b. For these plans, the per-person amount for family coverage needs to be less than or equal to the annual limitation on cost sharing for self-only coverage for the standard plan (\$7,350) and for the specific cost sharing reduction plan variations as detailed in the annual limitation on cost sharing discussion immediately above.⁸
 - c. If a plan is available for self-only coverage only (an individual plan), all family MOOP values may be entered as "Not Applicable." However, this self-only coverage must be reflected on the Business Rules Template when indicating the relationship types allowed. (See the Business Rules Template instructions for more details on offering self-only coverage and eligible dependent relationships.)
 3. Definition of **Not Applicable** and **\$0** for Deductible and MOOP.
 - a. Do not enter **Not Applicable** if there is a zero dollar deductible or MOOP; **\$0** is the appropriate data entry. For example, if a plan has a separate medical and drug deductible, and if there is no drug deductible, issuers must enter **\$0** as opposed to **Not Applicable**.
 - b. **Not Applicable** should be used in the *In Network* MOOP or deductible field only to imply that in-network service costs accumulate toward the entered *Combined In/Out of Network* MOOP or deductible.
 - c. If the *Individual In Network* and *Individual Combined In/Out of Network* deductible fields are equal to **Not Applicable**, the template returns an error when calculating the plan's AV using the AVC.
 4. To include multiple children in child-only plans, use the "family" MOOP and deductible fields to capture the data.
 5. The following explains how the values for various MOOP and deductible fields are related. Complete the fields as follows:
 - a. Some plans may have only combined in-network and out-of-network deductibles or MOOPs, rather than separate in-network and out-of-network deductibles or MOOPs. Other plans may have a mixture of in-network, out-of-network, and combined in-network and out-of-network deductibles or MOOPs. When defining deductibles and MOOPs, issuers must adhere to the guidelines.
 - b. If the plan does not have multiple in-network tiers, the following applies:
 - i. If the *In Network* field is equal to a dollar value (\$X), the *Combined In/Out of Network* field can be either a dollar value or **Not Applicable**.
 - ii. If the *In Network* field is **Not Applicable**, the *Combined In/Out of Network* field must be equal to a dollar value.
 - iii. The *Out of Network* field has no restrictions: it can be either a dollar value or **Not Applicable**.
 - c. If the plan has multiple in-network tiers, the following applies:

⁸ Ibid.

- i. If the *In Network* and *In Network (Tier 2)* fields are equal to dollar values, the *Combined In/Out of Network* field can be either a dollar value or **Not Applicable**.
- ii. If the *In Network* field is **Not Applicable**, the *In Network (Tier 2)* field must be **Not Applicable** and the *Combined In/Out of Network* field must be equal to a dollar value.
- iii. If the *In Network (Tier 2)* field is **Not Applicable**, the *In Network* field must be **Not Applicable** and the *Combined In/Out of Network* field must be equal to a dollar value.
- iv. The *Out of Network* field has no restrictions: it can be either a dollar value or **Not Applicable**.

5.2 Catastrophic Plan Instructions

Consistent with Section 1302(e) of the ACA and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can be offered only in the individual market.
2. They are permitted, but not required, to cover multiple-person enrollment (families) when all members meet eligibility requirements for this type of plan.
3. They do not have multiple in-network tiers for EHBs.
4. They have integrated medical and drug deductibles.
5. They have integrated medical and drug MOOPs.
6. They have an in-network deductible and in-network MOOP equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the ACA and in the HHS Notice of Benefit and Payment Parameters for 2018. For PY2018, this limit is \$7,350 for individuals (self-only) and \$14,700 for families (other than self-only).
7. They have an out-of-network deductible and out-of-network MOOP greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP, and a combined in/out-of-network deductible and combined in- and out-of-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
9. If they have a combined in- and out-of-network deductible and in- and out-of-network MOOP but no specific in-network deductible or in-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be equal to the annual limitation on cost sharing.
10. They have in-network cost sharing equal to no charge after the deductible for all EHBs, excluding primary care and preventive health services. (See Section 5.10 for direction on completing the copay and coinsurance fields to have this cost sharing value displayed to the consumer.)
11. All benefits except primary care visits and coverage of preventive health services—in accordance with Section 2713 of the PHS Act—are subject to the in-network deductible. Issuers must provide benefits for at least three primary care visits and coverage of preventive health services (in accordance with Section 2713 of the PHS Act) prior to the consumer reaching the deductible.
12. Coverage of preventive health services (in accordance with Section 2713 of the PHS Act) is not subject to the in-network deductible and does not impose any other cost sharing requirement.

5.3 Actuarial Value Details

For all AVs, whether calculated by the AVC or input by the issuer, the following requirements must be met:

1. A de minimis variation of ± 2 percentage points is used for standard plans.
 - a. The AV for a bronze plan must be between 58 percent and 62 percent.
 - b. The AV for an expanded bronze plan must be between 58 percent and 65 percent.

- c. The AV for a silver plan must be between 68 percent and 72 percent.
 - d. The AV for a gold plan must be between 78 percent and 82 percent.
 - e. The AV for a platinum plan must be between 88 percent and 92 percent.
2. A de minimis variation of ± 1 percentage point is used for silver plan variations.
 - a. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent.
 - b. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.
 - c. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
 3. The AV of a standard silver plan and the AV of the associated 73 percent silver plan variation must differ by at least 2 percentage points.
 4. The AV of the zero cost sharing plan variations must be 100 percent.
 5. The AV of the limited cost sharing plan variations must be equal to the associated standard plan's AV.

(For more information on how the cost sharing information from the Plans & Benefits Template translates to inputs for the stand-alone AVC, see Appendix 1.)

5.4 Editing the Template

Keep the following in mind when making changes to the template:

1. If a benefit is mistakenly added as an additional benefit, it cannot be manually deleted, but issuers may do one of the following:
 - a. Select **Not Covered** under the *Is this Benefit Covered?* column. When the Cost Share Variance worksheet is generated, this benefit will not appear on that worksheet.
 - b. Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but the issuer also loses any other data it has entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.
 - c. Additional steps need to be taken if the issuer has already created the Cost Share Variances worksheet. See below.
2. If an issuer changes whether a benefit is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, the benefits will not update the Cost Share Variances worksheet even if the issuer selects the **Update Cost Share Variances** button. Instead the issuer must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon and generate a new worksheet. The updated worksheet then reflects the changes made to the Benefits Package worksheet.
3. Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:
 - a. After adding a new plan to the Benefits Package worksheet, click the **Update Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon. This adds the new plan to the Cost Share Variances worksheet.
 - b. To delete a plan on the Benefits Package worksheet, delete all data for that plan's row. If any plans are below that row, cut these rows and paste them into the empty row (see below). This is an important step because if the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below this blank row and their corresponding data are deleted from the Cost Share Variances worksheet.
 - c. Example: To delete Plan 2 (Figure 2D-20), delete all data from the plan's row, cut and paste Plan 3 from Row 11 to Row 10, and then copy and paste Plan 4 from Row 12 to Row 11. Once those steps are completed, click the **Update Cost Share Variances** button; Plan 2 is removed from the Cost Share Variances worksheet while Plans 3 and 4 remain.

Figure 2D-20. Deleting a Plan

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI2222222	Plan 2
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10		
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI3333333	Plan 3
11	12345MI4444444	Plan 4
12		

- d. If the issuer changes any benefits package data on a specific plan that already exists, the only changes that will be reflected on the Cost Share Variances worksheet when the issuer clicks the **Update Cost Share Variances** button include the following: Plan Marketing Names will be updated, plans added to the Benefits Package worksheet will be added to the Cost Share Variance worksheet, and plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet. If there is a need to update the information for an existing plan, the issuer must first delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button. All previously entered information for this plan on the Cost Share Variances worksheet will be deleted. Reenter the plan and associated data on the Benefits Package worksheet, and click the **Update Cost Share Variances** button.

5.5 Requirements for Cost-Sharing Reduction Plan Variations

CSR plan variations fall into three types: silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations.

The zero-cost sharing and limited cost sharing plan variations are for American Indians and Alaska Natives. In the zero-cost sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs. In the limited cost sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian health care provider or from another provider if they have a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the amount consumers pay out-of-pocket for deductibles, coinsurance, and copayments, and there is also a lower MOOP. Consumers qualify for these plans if their income is below a certain level.

Each variation type has several requirements.

1. The requirements for zero cost sharing plan variations are as follows:
 - a. The template automatically generates a zero-cost sharing plan variation for all metal-level plans (except catastrophic) on the individual market.
 - b. The AV of the plan variation must be 100 percent.
 - c. All *In Network* MOOP values must be **\$0**. *Out of Network* and *Combined In/Out Network* MOOP values should be **\$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
 - d. All *In Network* deductible values must be **\$0**. *Out of Network* and *Combined In/Out Network* deductible values should be **\$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
 - e. All EHBs must have cost sharing values of **\$0**, **0%**, or **“no charge”** for both in- and out-of-network services.⁹ However, if the associated standard plan does not cover out-of-network services, the

⁹ Under 45 CFR 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but it excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

zero-cost sharing plan variation is not required to cover them either. (See Section 5.6 for details on indicating whether a benefit is an EHB.)

- f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated limited cost sharing plan variation. If the associated standard plan is a silver plan, the cost sharing also must follow successive cost sharing with the associated 94 percent AV silver plan variation. (See Section 5.7 for further explanation and examples of successive cost sharing.)
 - g. Tier utilization must be the same as the associated standard plan.
2. The requirements for limited cost sharing plan variations are as follows:
- a. The template automatically generates a limited cost sharing plan variation for all metal-level plans (except catastrophic) on the Individual Market.
 - b. The AV of the limited cost sharing plan variation must be greater than or equal to the associated standard plan's AV.
 - c. All MOOP values for EHB must be the same as the associated standard plan's MOOP values for EHB.
 - d. All deductible values must be the same as the associated standard plan's values.
 - e. All EHBs must have the same cost sharing values as the associated standard plan's values (see Section 5.6).
 - f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see Section 5.7).
 - g. Tier utilization must be the same as the associated standard plan.
3. The requirements for silver plan variations are as follows:
- a. Each silver plan offered on the Individual Market must have 73 percent AV, 87 percent AV, and 94 percent AV silver plan variations.
 - b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and it must also be at least 2 percentage points greater than the associated standard plan's AV.
 - c. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.
 - d. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
 - e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to \$5,850 for an individual (self-only) or \$11,700 for a family (other than self-only).
 - f. For the 87 percent and 94 percent AV silver plan variations, the MOOP must be less than or equal to \$2,450 for an individual (self-only) or \$4,900 for a family (other than self-only).
 - g. All MOOP values must follow successive cost sharing for all plan variations (see Section 5.7).
 - h. All deductible values must follow successive cost sharing for all plan variations.
 - i. The copay and coinsurance for all benefits must follow successive cost sharing for all plan variations.
 - j. Tier utilization must be the same as the associated standard plan.

5.6 EHB Variance Reason and EHB Designation

As explained in Section 5.5, benefits in the plan variations have specific requirements, depending on whether a benefit is considered an EHB. A benefit's EHB designation is based on the two fields *EHB* and *EHB Variance Reason* for the benefit on the Benefits Package worksheet as outlined in Section 4.10. Table 2D-1 explains when a benefit is considered an EHB on the basis of different inputs.

Table 2D-1. EHB Designation

<i>EHB</i> field value	<i>EHB Variance Reason</i> field value	<i>Evaluated as an EHB?</i>
Yes	Anything other than Not EHB	Yes
Blank	Additional EHB Benefit or Other Law/Regulation	Yes

<i>EHB field value</i>	<i>EHB Variance Reason field value</i>	<i>Evaluated as an EHB?</i>
Yes	Not EHB	No
Blank	Anything other than Additional EHB Benefit or Other Law/Regulation	No

5.7 Successive Cost Sharing Guidance

As explained in Section 5.5, successive cost sharing is required to be reviewed for multiple plan variations and data fields. The purpose of successive cost sharing is to ensure that a specific element in a given plan variation always has an equal or more generous cost sharing value for the consumer compared with a standard plan or plan variation. (See the HHS Notice of Benefits and Payment Parameters for details on the cost sharing regulatory requirements for cost sharing reduction plan variations.)

The following explains which plan variations should be compared depending on the requirement:

1. A standard silver plan and its associated silver plan variations must follow successive cost sharing for the MOOP, deductible, copay, and coinsurance fields. This includes EHBs and non-EHBs. All of the following must be true:
 - a. The cost sharing value of the 73 percent AV silver plan variation must be less than or equal to that of the associated standard plan.
 - b. The value of the 87 percent AV silver plan variation must be less than or equal to that of the 73 percent AV silver plan variation.
 - c. The value of the 94 percent AV silver plan variation must be less than or equal to that of the 87 percent AV silver plan variation.
2. A zero-cost sharing plan variation must follow successive cost sharing with the associated limited cost sharing plan variation for the copay and coinsurance fields for non-EHBs. This means that the value of the zero-cost sharing plan variation must be less than or equal to that of the limited cost-sharing plan variation.
3. A zero-cost sharing plan variation for a standard silver plan must follow successive cost sharing with the associated 94 percent AV silver plan variation for the copay and coinsurance fields for non-EHBs. This means the value of the zero-cost sharing plan variation must be less than or equal to that of the 94 percent AV silver plan variation.
4. A limited cost-sharing plan variation must follow successive cost sharing with the associated standard plan for the copay and coinsurance fields for non-EHBs. This means the value of the limited cost sharing plan variation must be less than or equal to that of the standard plan. The MOOP, deductible, and EHB cost sharing fields should be equal to that of the associated standard plan.

Again, the fields that may be used for successive cost sharing include MOOP, deductible, copay, and coinsurance. Because successive cost sharing requires that the plan always be equal or preferable to the consumer, changes to the cost sharing structures are not allowed when the consumer in the higher AV plan variation may be worse off and pay increased cost sharing. The following two examples illustrate noncompliant changes to the cost-sharing structure in the template:

1. A plan variation with a benefit that has 20 percent coinsurance may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a \$20 copay for the benefit. The better value depends on the total cost of the service.
2. A plan variation with a copay of \$5 after deductible may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a \$20 copay for a given benefit. The better value depends on whether the deductible has already been reached.

Table 2D-2 through Table 2D-8 show the compliant and noncompliant data entry options for the different cost sharing fields discussed, as well as numerous examples.

**Table 2D-2. Compliant and Noncompliant Successive Cost Sharing
Data Entry Options for MOOP or Deductible Values**

First plan (lower AV) MOOP/deductible value	Compliant second plan (higher AV) MOOP/deductible values	Noncompliant second plan (higher AV) MOOP/deductible values
\$X	◆ \$Y (when $\$Y \leq \X)	◆ Not Applicable ◆ \$Y (when $\$Y > \X)
Not Applicable	◆ Not Applicable	◆ \$Y

**Table 2D-3. Examples of Compliant (Green) and Noncompliant (Red)
Successive Cost Sharing MOOP/Deductible Values**

Example	MOOP/deductible	Compliance
Lower AV Plan	\$2,200	Compliant
Higher AV Plan	\$2,000	
Lower AV Plan	\$2,200	Not Compliant
Higher AV Plan	\$2,500	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	\$2,500	

Table 2D-4. Compliant and Noncompliant Successive Cost Sharing Options for Coinsurance Values

First plan (lower AV) coinsurance value	Compliant second plan (higher AV) coinsurance values	Noncompliant second plan (higher AV) coinsurance values
No Charge	◆ No Charge ◆ 0% Coinsurance ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (all values)
No Charge After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ 0% Coinsurance ◆ 0% Coinsurance After Deductible ◆ Not Applicable	◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (when greater than 0)
X% Coinsurance	◆ No Charge ◆ Y% Coinsurance (when $Y\% \leq X\%$) ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% \leq X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% \leq X\%$) ◆ Not Applicable	◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% > X\%$)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ No Charge After Deductible ◆ Y% Coinsurance (all values) ◆ Y% Coinsurance After Deductible (all values)

Table 2D-5. Examples of Compliant and Noncompliant Successive Cost Sharing Coinsurance Values

Plan	Coinsurance	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	0%	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	25%	Compliant
Higher AV Plan	20%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	25% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	30%	

Table 2D-6. Compliant and Noncompliant Successive Cost Sharing Data Entry Option for Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
No Charge	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Copay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
No Charge After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay ◆ \$0 Copay After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (when greater than 0) ◆ \$Y Copay With Deductible (all values)
\$X Copay	<ul style="list-style-type: none"> ◆ No Charge 	<ul style="list-style-type: none"> ◆ No Charge After Deductible

Table 2D-6. Compliant and Noncompliant Successive Cost Sharing Data Entry Option for Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y \leq \\X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$Y Copay (when $\\$Y \leq \\X) ◆ \$Y Copay After Deductible (when $\\$Y \leq \\X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (when $\\$Y > \\X) ◆ \$Y Copay With Deductible (all values)
\$X Copay With Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Copay ◆ \$Y Copay With Deductible (when $\\$Y \leq \\X) ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (when $\\$Y > \\X)
Not Applicable	<ul style="list-style-type: none"> ◆ Not Applicable ◆ No Charge 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

Table 2D-7. Compliant and Noncompliant Successive Cost Sharing Data Entry Options for Inpatient Specific Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
\$X Copay Per Day	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day (when $\\$Y \leq \\X) ◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day (when $\\$Y > \\X) ◆ \$Y Copay Per Stay (when $\\$Y > \\X) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ \$0 Copay Per Day ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay (when $\\$Y > \\X) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Day With Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when $\\$Y < \\X) ◆ \$Y Copay Per Stay With Deductible (when $\\$Y < \\X) 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when $\\$Y > \\X) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (when $\\$Y > \\X)

**Table 2D-7. Compliant and Noncompliant Successive Cost Sharing
Data Entry Options for Inpatient Specific Copay Values**

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay Per Day ◆ \$0 Copay Per Stay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay With Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (when \$Y < \$X) ◆ \$Y Copay Per Day With Deductible (when \$Y < \$X) ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay Per Stay ◆ \$0 Copay Per Day ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (when \$Y > \$X) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Day After Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day After Deductible (\$Y < \$X) ◆ \$Y Copay Per Stay After Deductible (\$Y < \$X) ◆ \$Y Copay Per Day (\$Y < \$X) ◆ \$Y Copay Per Stay (\$Y < \$X) ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Day (when \$Y > \$X) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Stay (when \$Y > \$X) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay After Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay After Deductible (\$Y < \$X) ◆ \$Y Copay Per Stay (\$Y < \$X) ◆ \$0 Copay Per Day After Deductible ◆ \$0 Copay Per Day ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Stay (when \$Y > \$X) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when greater than 0) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
No Charge After Deductible	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ No Charge ◆ \$0 Per Day ◆ \$0 Per Stay ◆ \$0 Copay Per Day After Deductible ◆ \$0 Copay Per Stay After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when greater than 0) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when greater than 0) ◆ \$Y Copay Per Day (when greater than 0) ◆ Not Applicable ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

**Table 2D-7. Compliant and Noncompliant Successive Cost Sharing
Data Entry Options for Inpatient Specific Copay Values**

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
No Charge	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Per Day ◆ \$0 Per Stay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Day (when greater than 0) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	\$0	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	\$40	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	\$45 Copay With Deductible	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	\$45 Copay After Deductible	
Lower AV Plan	\$40	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	\$40	Not Compliant
Higher AV Plan	\$40 Copay After Deductible	
Lower AV Plan	\$40	Not Compliant
Higher AV Plan	\$45	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$35 Copay After Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$35 Copay With Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$45	

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$40	
Lower AV Plan	\$40 Copay After Deductible	Compliant
Higher AV Plan	\$35 Copay After Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$35 Copay With Deductible	
Lower AV Plan	\$40 Copay After Deductible	Not Compliant
Higher AV Plan	\$45	
Lower AV Plan	\$40 Copay per Day	Compliant
Higher AV Plan	\$30 Copay per Day	
Lower AV Plan	\$40 Copay per Stay	Compliant
Higher AV Plan	\$40 Copay per Stay	
Lower AV Plan	\$40 Copay per Day	Not Compliant
Higher AV Plan	\$35 Copay per Stay	
Lower AV Plan	\$40 Copay per Day After Deductible	Compliant
Higher AV Plan	\$30 Copay per Day	
Lower AV Plan	\$40 Copay per Stay After Deductible	Compliant
Higher AV Plan	\$40 Copay per Stay	
Lower AV Plan	\$40 Copay per Day After Deductible	Not Compliant
Higher AV Plan	\$35 Copay per Stay With Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	\$35 Copay per Stay With Deductible	

5.8 Suggested Coordination of Drug Data between Templates

This section describes some options on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template.

To support the AV calculations using the AVC, the Plans & Benefits Template contains four drug benefit categories that represent a typical four-tier drug design available in the market today: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly into the Plans & Benefits Template. The following are some options for how issuers could translate their cost sharing data from the Prescription Drug Template into the Plans & Benefits Template:

1. Enter the cost sharing data for the tier in the Prescription Drug Template with the highest generic drug utilization into the Generic Drugs benefit category in the Plans & Benefits Template.
2. Enter the cost sharing data for the two tiers in the Prescription Drug Template with the most brand drug utilization into the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories in the Plans & Benefits Template. Enter the tier with the higher cost sharing into the Non-Preferred Brand Drugs category. If the formulary contains only one brand tier, enter the same cost sharing for the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories.

3. Enter the cost sharing data for the tier in the Prescription Drug Template with the most specialty drug utilization into the Specialty Drugs benefit category in the Plans & Benefits Template.

Cost sharing data should reflect the following:

1. The *Copay—In Network (Tier 1)* and *Coinsurance—In Network (Tier 1)* fields in the Plans & Benefits Template should generally correspond to the *1 Month In Network Retail Pharmacy Copayment* and *Coinsurance* fields from the Prescription Drug Template.
2. The *Copay—Out of Network* and *Coinsurance—Out of Network* fields in the Plans & Benefits Template should correspond to the *1 Month Out of Network Retail Pharmacy Copayment* and *Coinsurance* fields from the Prescription Drug Template.

The *Copay—In Network (Tier 2)* and *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template do not have corresponding fields in the Prescription Drug Template. While the concept of “tiers” is used as a framework to group drugs in the Prescription Drug Template, in the Plans & Benefits Template, “tiers” refer to provider and pharmacy networks. If the issuer has multiple in-network tiers for medical benefits, it may use the tiered cost sharing field for drugs to represent preferred and non-preferred pharmacies on the Plans & Benefits Template. Following this approach, the issuer could enter the cost sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to *In Network (Tier 1)*.
2. Non-preferred pharmacy cost sharing corresponds to *In Network (Tier 2)*.
3. If the issuer does not have multiple in-network tiers for its medical benefits, representing non-preferred pharmacy cost sharing under the *Tier 2* fields on the Plans & Benefits Template is not necessary.

If the plan has multiple in-network tiers for certain medical benefit categories, but not for drug benefits, set all drug benefit Tier 2 copay and coinsurance fields equal to **Not Applicable**.

The *Maximum Coinsurance for Specialty Drugs* field is defined only once in the Plans & Benefits Template for each plan; it cannot change among plan variations, and it must be the same for *In Network (Tier 1)*, *In Network (Tier 2)*, and *Out of Network*.

Cost sharing reduction plan variations must offer the same Drug List as the applicable standard plan. The cost sharing structure of the formulary for each plan variation must meet the requirements related to cost sharing reductions (45 CFR 156.420). However, issuers are not required to submit a separate formulary in the Prescription Drug Template for their plan variations.

Regardless of the method being used to translate the plan’s cost sharing data from the Prescription Drug Template into the Plans & Benefits Template, the inputs into the Plans & Benefits Template for the drug tiers should be reflective of the cost sharing being used in the AV calculation.

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Throughout this section, all data fields that CMS anticipates displaying to consumers on Plan Compare for individual market coverage are **identified by a number symbol (#)** next to the field name. Table 2D-9 and Table 2D-10 list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This should not be viewed as the final list of data elements for display to consumers, and CMS may change this list after these instructions are published. It is provided here as a reference for issuers before they submit QHP Applications.

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
Deductibles and Maximum Out of Pocket Rules	◆ If Medical and Drug amounts are integrated, the combined amount displays.	Plans & Benefits Template

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
	<ul style="list-style-type: none"> ◆ If Medical and Drug amounts are not integrated, only the medical amount displays on the Plan Summary View. (The Drug amount displays in the prescription drug details section.) ◆ If there is only one person in the enrollment group, the individual amount displays. ◆ If there is more than one person in the enrollment group, the Family Per Group amount displays. The dollar amount will display followed by “Per Group.” ◆ If there is more than one person in the enrollment group and the plan design does not have a per-group deductible, then the per-person deductible will display on the Plan Summary View. The dollar amount will display followed by “Per Person.” 	
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template
	Combined Medical & Drug EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above).	Plans & Benefits Template
Maximum Out of Pocket	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
Metal Level	Level of Coverage	Plans & Benefits Template
Provider Directory	Network URL	Network ID
Summary of Benefits and Coverage	URL for Summary of Benefits & Coverage	Plans & Benefits Template
Insurance Company + Plan Marketing Name + Plan Type <i>Issuer Legal Name (HIOS) will display if Issuer Marketplace Marketing Name is null</i>	Issuer Marketplace Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care (Adult) Major Dental Care—Adult Note: All three must be available to show Adult Dental Included	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child Note: All three must be available to show Pediatric Dental Included	Plans & Benefits Template
National Provider Network Offered/National Network	National Network	Plans & Benefits Template
Health Care Costs	Derived from “Level of Coverage”	Plans & Benefits Template
Reduced Costs	Indicates whether plan is a CSR variant	Based on Consumer Eligibility information

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Plan Brochure	Plan Brochure URL	Plans & Benefits Template
Benefit Data Rules This data displays for each covered benefit below when "Is This Benefit Covered?" value is "Yes"	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit "Limits and Exclusions Apply" hyperlink displays when Explanation or Exclusions is not null	Plans & Benefits Template
Medical Care Coverage		
Visit to a Primary Care Provider	Primary Care Visit to Treat an Injury or Illness	Plans & Benefits Template
Visit to a Specialist	Specialist Visit	Plans & Benefits Template
X-Rays and Diagnostic Imaging	X-Rays and Diagnostic Imaging	Plans & Benefits Template
Laboratory and outpatient professional services	Laboratory Outpatient and Professional services	Plans & Benefits Template
Hearing Aids	Hearing Aids	Plans & Benefits Template
Routine Eye Exam for Adults	Routine Eye Exam for Adults	Plans & Benefits Template
Routine Eye Exam for Children	Routine Eye Exam for Children	Plans & Benefits Template
Eyeglasses for Children	Eyeglasses for Children	Plans & Benefits Template
Health Savings Account Eligible Plan	HSA—Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template
3 Month In-Network Mail Order Pharmacy Benefit Offered?	3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug Template
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When "Medical & Drug Deductibles Integrated?" value is "Yes," "Included with Medical" displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out-of-Pocket: In-Network—Individual Drug EHB Maximum Out-of-Pocket: In-Network—Family (When "Medical & Drug MOOP Integrated?" value is "Yes," "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
Provider Directory	Network URL	Network ID
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral required to see a specialist	Plans & Benefits Template
Hospital Based Services		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient Hospital Services (e.g., Hospital Stay)	Plans & Benefits Template
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
Coverage Examples		
Total Cost of Having a Baby	SBC Scenario—Having a Baby. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Total Cost of Treating a Simple Fracture	SBC Scenario—Treatment of a Simple Fracture. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
Orthodontia	Orthodontia—Adult	Plans & Benefits Template
Find Dentists	Network URL	Network ID
Pediatric Dental Coverage		
Check-Up	Dental Check-Up for Children	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Child	Plans & Benefits Template
Major Dental Care	Major Dental Care—Child	Plans & Benefits Template
Orthodontia	Orthodontia—Child	Plans & Benefits Template
Medical Management Programs		
Asthma	Disease Management Programs Offered	Plans & Benefits Template
Heart Disease	Disease Management Programs Offered	Plans & Benefits Template
Depression	Disease Management Programs Offered	Plans & Benefits Template
Diabetes	Disease Management Programs Offered	Plans & Benefits Template
High Blood Pressure & Cholesterol	Disease Management Programs Offered	Plans & Benefits Template
Low Back Pain	Disease Management Programs Offered	Plans & Benefits Template
Pain Management	Disease Management Programs Offered	Plans & Benefits Template
Pregnancy	Disease Management Programs Offered	Plans & Benefits Template
Weight Loss Program	Disease Management Programs Offered	Plans & Benefits Template
Other Benefits		
Acupuncture	Acupuncture	Plans & Benefits Template
Chiropractic Care	Chiropractic Care	Plans & Benefits Template
Infertility Treatment	Infertility Treatment	Plans & Benefits Template
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health Outpatient Services	Plans & Benefits Template
Mental/Behavioral Health Inpatient Services	Mental/Behavioral Health Inpatient Services	Plans & Benefits Template
Habilitative Services	Habilitative Services	Plans & Benefits Template
Bariatric Surgery	Bariatric Surgery	Plans & Benefits Template
Outpatient Rehabilitative Services	Outpatient Rehabilitation Services	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Skilled Nursing Facility	Skilled Nursing Facility	Plans & Benefits Template
Private-Duty Nursing	Private-Duty Nursing	Plans & Benefits Template

5.10 Plan Compare Cost-Sharing Display Rules

Below is a summary of the anticipated deductible, MOOP, copay, and coinsurance cost sharing display logic for Plan Compare for Individual Market coverage effective starting January 1, 2018. It covers the majority of situations but is not exhaustive. This should not be viewed as the final display logic for Plan Compare, and CMS may make changes after these instructions are published. It is provided here as a reference for issuers before submitting QHP Applications.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- ◆ If medical and drug amounts are integrated, then the total amount for the medical and drug data element will display on the Plan Summary page. “Included with Medical” will display on the plan details page under the drug amounts.
- ◆ If medical and drug amounts are not integrated, only the medical amount displays on the plan summary page. The drug amount displays in the prescription drug details section on the plan detail page.
- ◆ If only one person is in the enrollment group, the individual MOOP and deductible amount displays on the plan summary and plan details pages.
- ◆ On the plan summary page, if more than one person is in the enrollment group, the Family Per Group MOOP amount displays. The dollar amount will display followed by “Per Group.”
- ◆ On the plan summary page, if there is more than one person in the enrollment group, a family per-group deductible amount displays on the plan summary page if the issuer entered either \$0 or a positive dollar amount for the family per-group data field. The dollar amount will display followed by “Per Group.” If there is more than one person in the enrollment group and the plan design does not have a per-group deductible (i.e., the Family Per Group Deductible is “Not Applicable”), then the per-person deductible will display on the Plan Summary View. The dollar amount will display followed by “Per Person.”
- ◆ On the plan details page, the Family Per Group and the Family Per Person deductible and MOOP amounts will appear.
- ◆ The out-of-network deductible and MOOP are not displayed on Plan Compare.

5.10.2 Covered Benefit Plan Compare Display Logic

- ◆ Generally speaking, the Plan Compare display logic considers the entered values for copay and coinsurance. For example, if the issuer enters “Not Applicable” for copay and “20%” for coinsurance for a specialist visit, “20%” will display on Plan Compare.
- ◆ When copay is “Not Applicable” and rounded coinsurance is greater than zero and less than 100 percent, the coinsurance value is displayed.
- ◆ When copay is greater than zero and coinsurance is “Not Applicable,” the entered copay value is displayed.
- ◆ If coinsurance is equal to “100%,” a benefit is displayed as “Not Covered.”
- ◆ “No Charge After Deductible” is displayed if the following occurs:
 - “No Charge After Deductible” is entered for copay and coinsurance.
 - The issuer entered “Not Applicable” for copay and “No Charge After Deductible” for coinsurance, or vice versa.

- ◆ “No Charge” is displayed when the combination of entered copay and coinsurance values include “0,” “No Charge,” or “Not Applicable.” Similarly, if any of the aforementioned values include copay or coinsurance qualifiers of “After Deductible,” then “No Charge After Deductible” is displayed.
- ◆ When copay and coinsurance are each greater than zero, both are displayed.

5.11 Troubleshooting the Plans & Benefits Add-In File

When opening the Add-In file before the template, Excel sometimes loads an older version of the Add-In file not compatible with the template. This causes run-time errors when entering data into the template or clicking buttons on the **Plans & Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for best results.
2. Never rename the Add-In file to a different name.
3. Ensure that only one copy of the Add-In file is on the computer; delete all extra copies. When downloading a new one, always “Replace” the old version.

If the issuer still experiences run-time errors, Excel may have loaded a previous version of the Add-In file. Take the following steps:

1. Open Excel only (no template or file). The Excel ribbon should not have a **Plans & Benefits** ribbon. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (Figure 2D-21 through Figure 2D-23). In Excel 2007, the labels may differ slightly.

Figure 2D-21. Excel Options Window

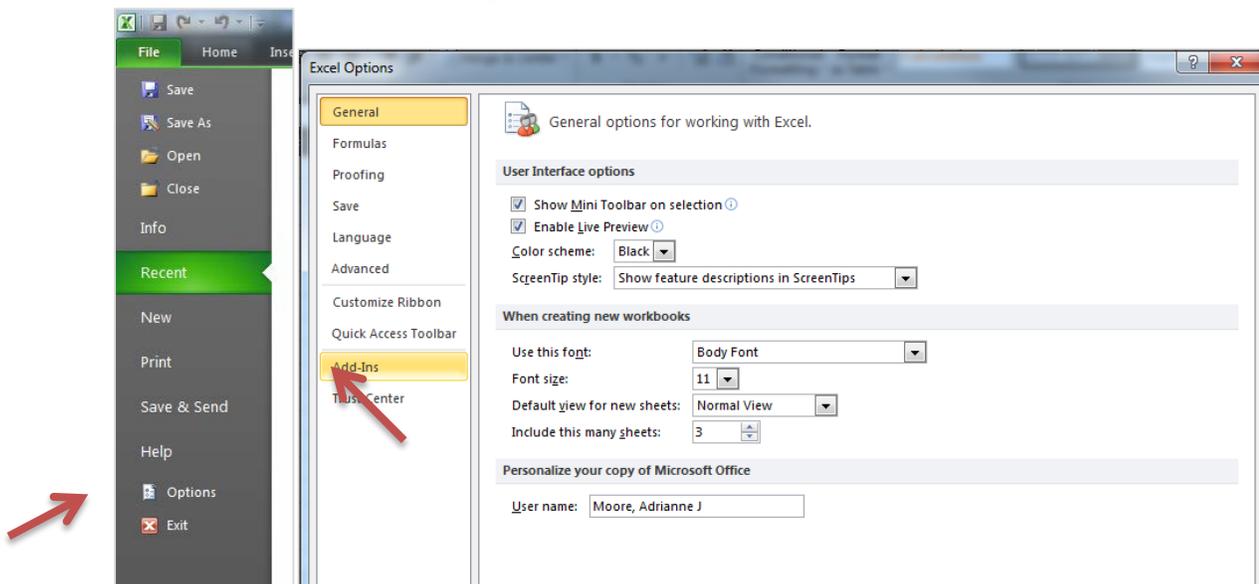


Figure 2D-22. Add-Ins Tab in Excel Options Window

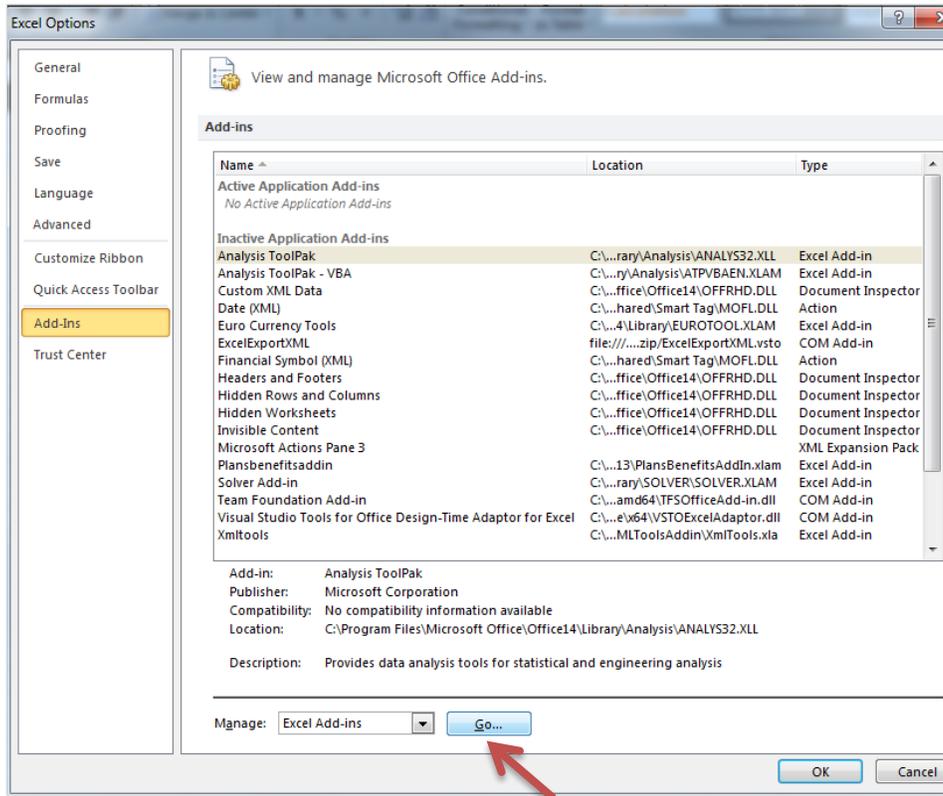
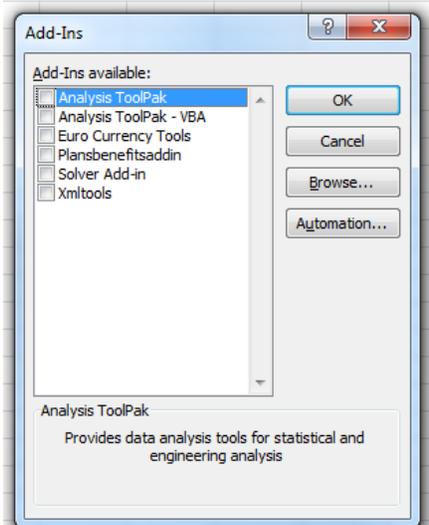


Figure 2D-23. Add-Ins Window



2. Verify that the **Plans & Benefits** ribbon is gone.
3. Open a Plans & Benefits Template.
4. The template should open the Add-In automatically after **Enable Macros** is clicked. This means the template successfully loaded the Add-In.

5.12 Simple Choice Plan Design and Corresponding Add-In File

1. The **Simple Choice Plan** Add-In file is provided to assist users in populating all cost sharing information for plans that are using a Simple Choice plan design. The details for the purpose and parameters of the Simple Choice plans are specified in the HHS Notice of Benefit and Payment Parameters for 2018.
2. The purpose of Simple Choice plan options is to simplify the consumer shopping experience by providing plans that consumers can more easily compare across issuers in the individual market. In each state, there will be one set of Simple Choice plan options with a specified cost sharing structure at each of the bronze, silver, silver CSR (73% AV, 87% AV, and 94% AV plan variation), gold, and bronze HDHP metal levels. Each Simple Choice plan design has a set deductible, MOOP, and copay or coinsurance value for a key set of EHBs. Those benefits include urgent care and all EHBs that are in the AVC, as they comprise a large percentage of the total allowable costs for an average enrollee. Other benefits and plan features are not standardized and may vary by issuers.
3. Table 2D-11 through Table 2D-13 show the covered benefits and cost sharing amounts for each of the Simple Choice plan designs. All plan designs in the second set of standardized options apply to Marketplace(s) in the states of Delaware, Iowa, Kentucky, Louisiana, Missouri, Montana, and New Hampshire. The third set of standardized options applies to the Marketplace in New Jersey. The plan designs in the first set of options apply to issuers in all other states.

Note: Simple Choice plan designs are not applicable to SADPs, and there are no Simple Choice plan options for the Catastrophic and Platinum metal levels or SHOP plans. Also, note that each silver plan CSR variation has its own Simple Choice plan design.

Table 2D-11. 2018 Simple Choice Plan Options—Set One

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	62.68%	61.97%	71.05%	73.95%	87.61%	94.69%	80.65%
Deductible (Med/Rx)	\$6,650	\$6,000	\$3,500/ \$500	\$3,000/ \$200	\$700/\$0	\$250/\$0	\$1,400/\$0
Annual Limitation on Cost Sharing	\$7,350	\$6,000	\$7,350	\$5,850	\$2,450	\$1,250	\$5,000
Emergency Room Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Urgent Care	\$75 (*)	No charge after deductible	\$75 (*)	\$75 (*)	\$40 (*)	\$25 (*)	\$60 (*)
Inpatient Hospital Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Primary Care Visit	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Specialist Visit	\$75 (*)	No charge after deductible	\$65 (*)	\$65 (*)	\$25 (*)	\$10 (*)	\$50 (*)

Table 2D-11. 2018 Simple Choice Plan Options—Set One

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Mental Health/ Substance Use Disorder Outpatient Office Visit	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Imaging (CT/PET Scans, MRIs)	40%	No charge after deductible	20%	20%	20%	5%	20%
Speech Therapy	40%	No charge after deductible	20%	20%	20%	5%	20%
Occupational Therapy/Physical Therapy	40%	No charge after deductible	20%	20%	20%	5%	20%
Laboratory Services	40%	No charge after deductible	20%	20%	20%	5%	20%
X-rays and Diagnostic Imaging**	40%	No charge after deductible	20%	20%	20%	5%	20%
Skilled Nursing Facility	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Generic Drugs	\$35 (*)	No charge after deductible	\$15 (*)	\$15 (*)	\$5 (*)	\$3 (*)	\$10 (*)
Preferred Brand Drugs	35%	No charge after deductible	\$50 (*)	\$50 (*)	\$25 (*)	\$5 (*)	\$40 (*)
Non-Preferred Brand Drugs	40%	No charge after deductible	\$100 (*)	\$100 (*)	\$50 (*)	\$10 (*)	\$75 (*)
Specialty Drugs	45%	No charge after deductible	40%	40%	30%	25%	30%

(*) = not subject to the deductible.

** Excludes X-rays and diagnostic imaging associated with office visits (except for HDHPs).

Table 2D-12. 2018 Simple Choice Plan Options—Set Two

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	62.79%	61.97%	71.03%	73.88%	87.70%	94.68%	80.60%
Deductible (Med/Rx)	\$6,650	\$6,000	\$3,500/ \$500 Rx	\$3,000/ \$200 Rx	\$700/\$0	\$250/\$0	\$1,400/\$0
Annual Limitation on Cost Sharing	\$7,350	\$6,000	\$7,350	\$5,850	\$2,450	\$1,250	\$5,000
Emergency Room Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Urgent Care	\$75 (*)	No charge after deductible	\$75 (*)	\$75 (*)	\$40 (*)	\$25 (*)	\$60 (*)
Inpatient Hospital Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Primary Care Visit	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Specialist Visit	\$75 (*)	No charge after deductible	\$65 (*)	\$65 (*)	\$25 (*)	\$10 (*)	\$50 (*)
Mental Health/ Substance Use Disorder Outpatient Office Visit	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Imaging (CT/PET Scans, MRIs)	40%	No charge after deductible	20%	20%	20%	5%	20%
Speech Therapy	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Occupational Therapy/Physical Therapy	\$35 (*)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$20 (*)
Laboratory Services	40%	No charge after deductible	20%	20%	20%	5%	20%
X-rays and Diagnostic Imaging**	40%	No charge after deductible	20%	20%	20%	5%	20%
Skilled Nursing Facility	40%	No charge after deductible	20%	20%	20%	5%	20%

Table 2D-12. 2018 Simple Choice Plan Options—Set Two

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Generic Drugs	\$35 (*)	No charge after deductible	\$15 (*)	\$15 (*)	\$5 (*)	\$3 (*)	\$10 (*)
Preferred Brand Drugs	\$40 (copay applies only after deductible)	No charge after deductible	\$50 (*)	\$50 (*)	\$25 (*)	\$5 (*)	\$40 (*)
Non-Preferred Brand Drugs	\$45 (copay applies only after deductible)	No charge after deductible	\$100 (*)	\$100 (*)	\$50 (*)	\$10 (*)	\$75 (*)
Specialty Drugs	\$50 (copay applies only after deductible)	No charge after deductible	\$150 (copay applies only after drug deductible)	\$150 (copay applies only after drug deductible)	\$75 (*)	\$20 (*)	\$100(*)

(*) = not subject to the deductible.

** Excludes x-rays and diagnostic imaging associated with office visits (except for HDHPs).

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	64.84%	61.97%	71.53%	73.63%	87.61%	94.53%	80.80%
Deductible (Med/Rx)	\$3,000	\$6,000	\$2,500	\$2,500	\$700	\$250	\$1,000
Annual Limitation on Cost Sharing	\$7,150	\$6,000	\$7,150	\$5,850	\$2,450	\$1,250	\$5,000

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Emergency Room Services	50%	No charge after deductible	40%	30%	20%	5%	30%
Urgent Care	\$50 (*)	No charge after deductible	\$50 (*)	\$50 (*)	\$40 (*)	\$25 (*)	\$40 (*)
Inpatient Hospital Services	\$500 (per day; applies only after deductible)	No charge after deductible	40%	30%	20%	5%	30%
Primary Care Visit	\$35 (*first 3 visits; then subject to deductible and \$35 copay after deductible)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$25 (*)
Specialist Visit	\$75 (applies only after deductible)	No charge after deductible	\$60 (*)	\$60 (*)	\$25 (*)	\$10 (*)	\$40 (*)
Mental Health/ Substance Use Disorder Outpatient Office Visit	\$35 (applies only after deductible)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$25 (*)
Imaging (CT/PET Scans, MRIs)	\$100 (applies only after deductible)	No charge after deductible	\$100 (*)	\$100 (*)	\$75 (*)	\$40 (*)	\$100 (*)
Speech Therapy	\$35 (applies only after deductible)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$25 (*)
Occupational Therapy/Physical Therapy	\$35 (applies only after deductible)	No charge after deductible	\$30 (*)	\$30 (*)	\$10 (*)	\$5 (*)	\$25 (*)
Laboratory Services	50%	No charge after deductible	40%	30%	20%	5%	30%
X-rays and Diagnostic Imaging**	50%	No charge after deductible	40%	30%	20%	5%	30%
Skilled Nursing Facility	\$500 (per day; applies only after deductible)	No charge after deductible	40%	30%	20%	5%	30%

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	50%	No charge after deductible	40%	30%	20%	5%	30%
Outpatient Surgery Physician/Surgical Services	50%	No charge after deductible	40%	30%	20%	5%	30%
Generic Drugs	\$25 (*)	No charge after deductible	\$25 (*)	\$25(*)	\$5 (*)	\$3 (*)	\$10 (*)
Preferred Brand Drugs	50%	No charge after deductible	\$50 (*)	\$50 (*)	\$25 (*)	\$5 (*)	\$25 (*)
Non-Preferred Brand Drugs***	50%	No charge after deductible	\$75 (*)	\$75 (*)	\$50 (*)	\$10 (*)	\$50 (*)

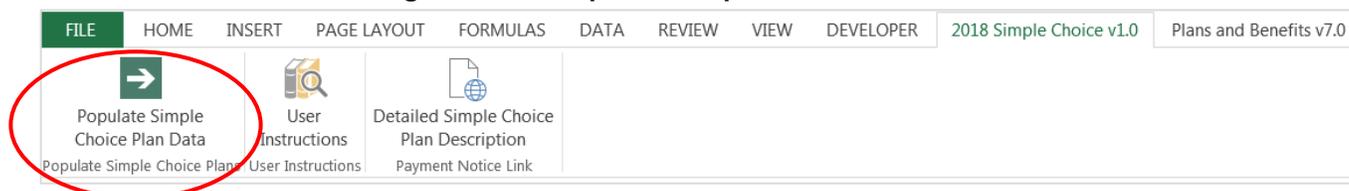
(*) = not subject to the deductible.

** Excludes x-rays and diagnostic imaging associated with office visits (except for HDHPs).

***For compliance with applicable New Jersey state requirements, the Simple Choice plan options are limited to three drug tiers. They do not have a separate specialty drug tier. For the purposes of calculating the AV using the AVC, which is based on a four-drug tier system, the cost saving value for non-preferred brand drugs will be assigned to the specialty drug tier.

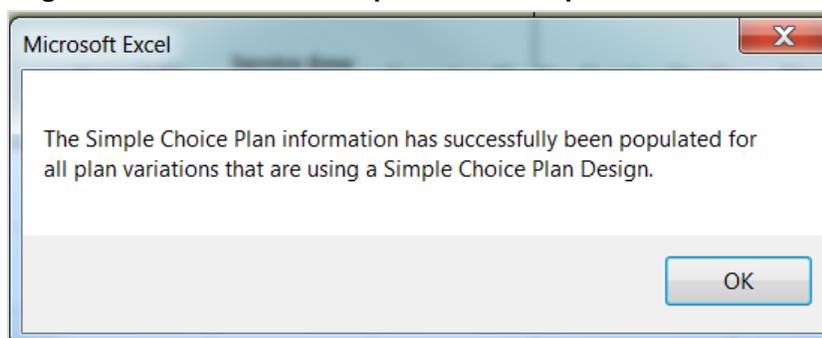
4. If the issuer intends to apply the Simple Choice plan design to a plan at a given metal level, it must select **Design 1, Design 2, Design 3, Design 4, or Design 5** from the drop-down menu in the *Design Type* field. If the issuer has only one Simple Choice plan at a given metal level, it would select **Design 1**. If the issuer has two or more Simple Choice plans at a given metal level, it would select **Design 1** for the first one, **Design 2** for the second, and so on.
5. Populate the rest of the Benefits Package worksheet following the instructions detailed in Section 4 of these instructions.
 - a. On each Benefits Package worksheet that has one or more plans using a Simple Choice plan design, ensure that every benefit listed in Table 0-11 above is set as **Covered** under the *Is this Benefit Covered?* field; otherwise, the Add-In will not run.
6. Create the corresponding Cost Share Variances worksheet using the Plans & Benefits Add-In file. For further instructions on how to create a Cost Share Variances worksheet, please refer to Section 4.
7. To load the Simple Choice Plan Add-In, open the file. Unlike the Plans & Benefits Template Add-In, open the Simple Choice Plan Add-In or it will not load into the Plans & Benefits Template.
8. Press the **Populate Simple Choice Plan** button under the **Simple Choice Plan Add-In** ribbon (Figure 2D-24).

Figure 2D-24. Populate Simple Choice Plan Button



9. If everything runs correctly, the issuer will see the message below appear (Figure 2D-25); otherwise an error message will appear and indicate what needs to be corrected to proceed. After everything has been corrected, press the **Populate Simple Choice Plan** button again.
 - a. The **Populate Simple Choice Plan** button will populate every field listed in Table 2D-11 on the Cost Share Variances worksheet. The populated values depend on the metal level of the Simple Choice plan and correspond to the values listed in Table 2D-11.

Figure 2D-25. Successful Population of Simple Choice Plan Data

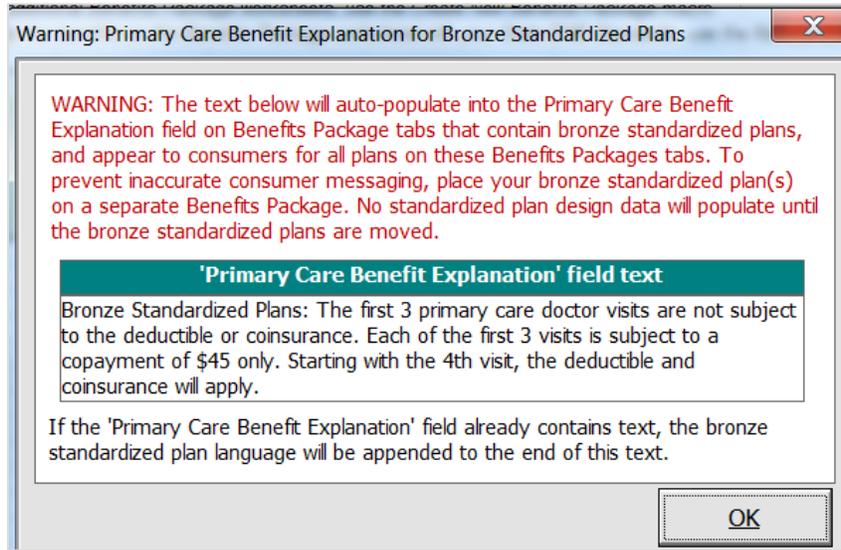


10. There are now two bronze Simple Choice plans in each set: a conventional bronze Simple Choice plan and a bronze high deductible health plan (HDHP). Both of these Simple Choice plans should have the metal level of Expanded Bronze. To indicate which bronze Simple Choice plan the issuer wants to implement, use the *HSA Eligible* field in the Cost Share Variances worksheet to indicate which Simple Choice plan you intend to offer. If you want a plan to follow the Simple Choice plan for the conventional bronze plan, please select “No” for the field *HSA Eligible*.” If you want the plan to follow the Simple Choice plan for the HDHP bronze, select “Yes” for the field *HSA Eligible*.
11. For plans in New Jersey (Simple Choice Plan Options—Set Three), the text below will auto-populate into the *Primary Care Benefit Explanation* field on Benefits Package tabs that contain bronze Simple Choice plans, and it will appear to consumers for all plans on these Benefits Package tabs. To prevent inaccurate consumer messaging, place the bronze Simple Choice plan(s) on a separate Benefits Package. No Simple Choice plan data will populate until the bronze Simple Choice plans are moved (Figure 2D-26). If the *Primary Care Benefit Explanation* field already contains text, the bronze Simple Choice plan language will be appended to the end of this text.

“Bronze Simple Choice Plans: The first 3 primary care doctor visits are not subject to the deductible or coinsurance. Each of the first 3 visits is subject to a copayment of \$35 only. Starting with the 4th visit, the deductible and MOOP will apply.”

Additionally, an error was included in the 2018 Payment Notice for the silver Simple Choice plan. Please note that the cost sharing for “Speech Therapy” and “Occupational and Physical Therapy” is a \$30 copay, corrected from a \$50 copay. The add-in file will automatically populate the correct amounts.

Figure 2D-26. New Jersey Bronze Simple Choice Plan Warning Message



12. The **Simple Choice Plan Add-In** file contains two buttons in addition to the main **Populate Simple Choice Plan** button.
 - a. The **User Instructions** button (Figure 2D-27) contains convenient abbreviated instructions similar to the instructions detailed here for reference while working in the Plans & Benefits Template.
 - b. The **Detailed Simple Choice Plan Description** (Figure 2D-28) button hyperlinks to the HHS Notice of Benefit and Payment Parameters for 2018 for a detailed description of the Simple Choice plans purpose and parameters.

Figure 2D-27. User Instructions Button

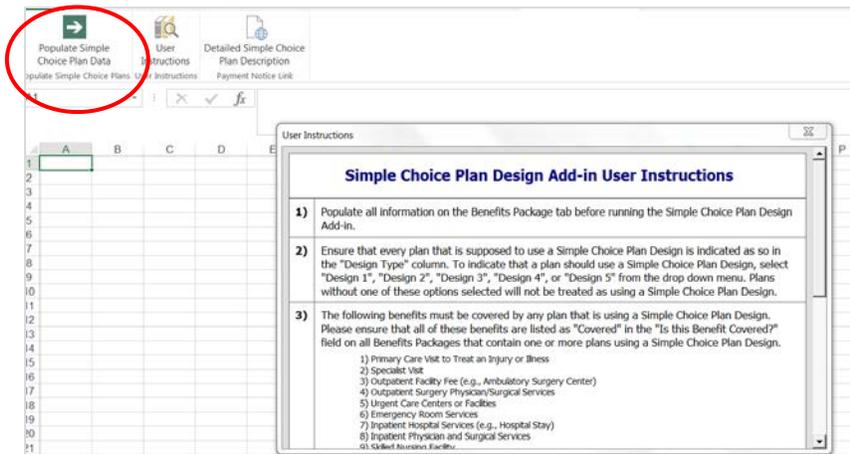
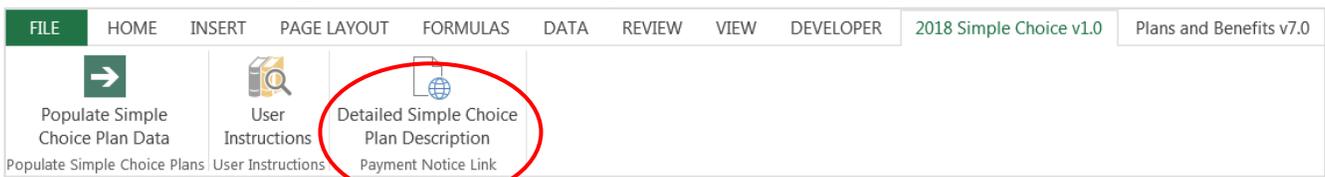


Figure 2D-28. Detailed Simple Choice Plan Description Button



Rating Module

Users of the Rating Module are assigned to one or both of the following roles: the Issuer Submitter, an individual who submits the data necessary to complete the Rating Module, and the Issuer Validator, an individual who validates the data necessary to complete the Rating Module.

This module is divided into various sections, and the tabs to navigate through the sections of the module are listed on the top of the page. There are three tabs to this module: the Data Submitter page, the Data Validator page, and the Final Submission page (Figure 3-1).

Figure 3-1. Three Module Tabs



The Data Submitter page allows submitters to work on an existing application or view an application that the issuer already submitted (Figure 3-2). The Data Validator page allows validators to view a list of all submitted applications. This section also allows validators to upload supporting documents and answer supplemental responses through HIOS (Figure 3-3). The Final Submission page allows the submitter to cross-validate data between modules and submit the QHP Application (Figure 3-4).

Each of these tabs is broken down further with information that needs to be entered to create a new application or edit an existing application. For the Data Submitter page, all sections listed in the lower section and to the left-hand side of the page need to be completed before moving on to the Data Validator pages.

Figure 3-2. Upload/Download Data Submitter Page

Upload/Download Rates & Business Rules

Download Templates

- BusinessRules.xls
- Rates.xls

Upload File(s)
Fields marked with an asterisk (*) are required.

Information: Please note that uploading a second version of the template will replace the previously uploaded version.

Document Type: Select document type [dropdown] **Upload File(s):** Browse... No file selected. **Upload**

Uploaded File History Update Status

Document Type:	File Name	Submission Date	Status
Business Rules	07296_NC_2016_BusinessRules.xls	02/17/2015 2:40:22 PM	Complete
Rules	07296_NC_2016_Mod_Rates.xls	02/17/2015 2:48:33 PM	Pending

Figure 3-3. Data Validator Snapshot

Data Submitter
Data Validator
Final Submission

Validate The Rates & Business Rules Submission

Please review and validate the completed submissions.
Fields marked with an asterisk (*) are required.

Uploaded File(s)

Document Type:	File Name	Upload Date
Business Rules	87296_NC_2016_BusinessRules.xls	02/17/2015 2:48:22 PM
Rates	87296_NC_2016_Med_Rates.xls	02/17/2015 2:48:40 PM

*Do you validate that the information submitted for this section is correct?

Yes No

Figure 3-4. Final Submission Snapshot

Data Submitter
Data Validator
Final Submission

Issuer ID 87296 has been Cross Validated.

To qualify for QHP Certification, Cross Validation must be passed. To cross validate template data within a submission, click the Cross Validate or Submit Button. A submission must pass cross validation prior to the submission window closing in order to be a certified QHP.

Please Note: The Rate Review module submission(s) are required in order to successfully complete cross-validation.

Module	Submission Date	Status
Issuer Module	02/17/2015 3:32:53 PM	Validation Completed
Benefits and Service Area Module	02/17/2015 4:09:42 PM	Validation Completed
Rating Module	02/17/2015 3:05:11 PM	Validation Completed

Section 3A: Rates Table

1. Introduction

In the Rates Table section, issuers must define the premium rate that the issuer charges for each type of subscriber that a plan covers. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID;
2. Federal Taxpayer Identification Number (TIN); and
3. Plan IDs.

3. Quick Reference

Key Changes for 2018

- ◆ In the Rating Method variable, issuers indicate whether all plans on a worksheet use age-based rates or family-tier rates.
- ◆ For plans using age-based rates, there are child age bands for ages 0–14, 15, 16, 17, 18, 19, and 20. These replace the 0–20 child age band found in previous template versions.
- ◆ For plans using age-based rates, there is a 64 and over age band. This replaces the 64 and 65 and over age bands found in previous template versions.

Tips for the Rates Section

- ◆ SADPs should be entered on a separate Rates Table Template from QHPs.
- ◆ Issuers are encouraged to use separate sheets for individual plans and SHOP plans.
- ◆ For individual market plans, the rate effective date must be January 1, 2018.
- ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1st, April 1st, July 1st, or October 1st). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect.

4. Detailed Section Instructions

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Federal TIN	Enter the 9-digit (xx-xxxxxxx) TIN.
Rate Effective Date	<p>Enter the rate effective date as mm/dd/yyyy.</p> <p>For individual market plans, the rate effective date must be January 1, 2018.</p> <ul style="list-style-type: none"> ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1st, April 1st, July 1st, and October 1st). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect. ◆ An issuer submitting a SHOP quarterly rate change should submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable quarterly rate change submission window. An issuer may submit rate changes that would apply for the next quarter and/or any subsequent quarter in the remaining plan year. An issuer should not change or delete rates for any current or previous quarter during the submission window. For example, during the submission for updated second quarter SHOP rates, the first quarter rates should match the original submission. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding Unified Rate Review Template.
Rate Expiration Date	<p>Enter the rate expiration date as mm/dd/yyyy.</p> <ul style="list-style-type: none"> ◆ For individual market plans, the rate expiration date must be December 31, 2018. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (March 31st, June 30th, September 30th, or December 31st).
Rating Method	<p>Select whether the plans on the worksheet use age-based rates or family-tier rates.</p> <p>Note: Only issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers or issuers entering rates for individual market SADPs are eligible to select "Family-Tier Rates." A list of states that use family-tier rating is available here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html#family</p>
Add Sheets	<p>Use the Add Sheet button to add additional worksheets for the following:</p> <ul style="list-style-type: none"> ◆ If the issuer has SHOP plans with different rate effective and expiration dates. All plans on a single worksheet <u>must</u> have the same effective and expiration dates. ◆ To separate individual market plans and SHOP plans. ◆ If the issuer offers individual market SADPs that use individual and family-tier rating. Note that FF SHOP and SP SHOP (State Partnership Small Group Health Options Program) SADPs can only use individual rating. ◆ To separate by rating area.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (xxxxxAxxxxxxx) that identifies the plan associated with the rates in that row.
Rating Area	Select the rating area from the list. The rating area is the geographic area where the rates in the row are valid. Rating areas are defined by each state. A list of rating areas for each state is available here: http://cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html .

Rates Table Template	Steps
Tobacco	<p>If using age-based rates, select from the following options in the drop-down menu to indicate whether rates vary on the basis of tobacco use:</p> <ul style="list-style-type: none"> ◆ Tobacco User/Non-Tobacco User—if rates are different for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.¹⁰ <p>Note: Small group market medical plans (including SHOP QHPs) with tobacco rating <u>must</u> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act, and indicate the wellness program on their Plans & Benefits Template. If the plan does not offer such a wellness program, the plan cannot rate for tobacco use.</p> <p>Note: For FF SHOP and SP SHOP, if an enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used.</p> ◆ No Preference—if the rate applies to tobacco and non-tobacco users. No separate rates should be submitted for tobacco and non-tobacco users.
Age	<p>If using age-banded rates, the template will automatically generate a row for each age band 0–14 through 64 and over.</p> <ul style="list-style-type: none"> ◆ If the issuer elects to rate by tobacco use, then tobacco rates for the child age bands of 0–14, 15, 16, and 17 will be auto-populated with the non-tobacco rates of the corresponding child age bands if the non-tobacco rates are first entered in the template. The issuer will have the option of editing the auto-populated non-tobacco rates. ◆ For dental plans only: Individual market SADPs that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating age bands that are not present in this template. In the <i>Plan Attributes</i> section of the Plans & Benefits Template, individual market SADP issuers have the option to elect whether they are voluntarily complying with the rating rules in this template (“Guaranteed”), or if the issuer reserves the right to make further premium adjustments (“Estimated”). The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that to be offered on the Marketplace, FF SHOP and SP SHOP SADPs must provide guaranteed rates. <p>If the issuer is in a state that does not permit rating for age or tobacco use and establishes uniform family tiers (and corresponding multipliers), or is entering rates for an individual market SADP using “Family-Tier Rates” as the rating method, skip to <i>Family Tier</i>.</p>

¹⁰ 42 U.S. Code 300 gg – Fair Health Insurance Premiums.

Rates Table Template	Steps
Individual Rate	<ul style="list-style-type: none"> ◆ Enter the individual rate that applies to that row. Market rules require individual rates to vary on the basis of age by not more than 3 times the age-21 rate. In addition, QHPs may not have a 0–20 age rate higher than the 21-age rate and must follow the federal age-rating curve, or state age-rating curve for issuers in states with state age-rating curves within the 1:3 market rule. A list of states using state-specific age curve variations is available here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/state_specific_age_curve_variations_021317.pdf <p>Note: QHPs and SADPs must enter a value above \$0.00 for all age bands under the <i>Individual Rate</i> column unless the QHP or SADP has a value of “Allows Child-Only” under the <i>Child-only Offering</i> column of the Plans & Benefits Template. QHP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19 and 20 age bands and are allowed to enter a value of \$0.00 for adult age bands 21 through 64 and over. SADP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17 and 18 age bands and are allowed to enter a value of \$0.00 for adult age bands 19 through 64 and over.</p> <ul style="list-style-type: none"> ◆ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under the <i>Individual Tobacco Rate</i> column for age bands 18 through 64 and over. QHPs and SADPs are allowed to enter a value of \$0.00 as the tobacco rate for child age bands 0–14, 15, 16 and 17. QHP child-only offerings are allowed to enter a value of \$0.00 as the tobacco rate for adult age bands 21 through 64 and over. SADP child-only offerings are allowed to enter a value of \$0.00 as the tobacco rate for adult age bands 19 through 64 and over.
Family Tier	<p>Issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, or individual market SADP issuers that selected “Family-Tier Rates” in the rating method field will enter the individual rate in the individual rate field. Selecting “Family-Tier Rates” will also generate the following family tier columns:</p> <ul style="list-style-type: none"> ◆ Individual Rate (required): Enter the rate of an individual non-tobacco or no preference enrollee on a plan. ◆ Couple (required): Enter the rate for a couple. A couple is defined as a primary subscriber and his or her spouse. A couple may also be a domestic partnership or same-sex partnership if allowed by the issuer in the Business Rules Template. ◆ Primary Subscriber and One Dependent (required): Enter the rate for a primary subscriber with one dependent. ◆ Primary Subscriber and Two Dependents (required): Enter the rate for a primary subscriber with two dependents. ◆ Primary Subscriber and Three or More Dependents (required): Enter the rate for a primary subscriber with 3 or more dependents. ◆ Couple and One Dependent (required): Enter the rate for a couple with one dependent. ◆ Couple and Two Dependents (required): Enter the rate for a couple with two dependents. ◆ Couple and Three or More Dependents (required): Enter the rate for a couple with 3 or more dependents. <p>In the family tier option defined above, a dependent is defined as any dependent relationship allowed by the issuer that falls under the maximum age of a dependent as defined in the Business Rules Template. If any member of the enrollment group is determined to be ineligible, no rate will be returned for that plan.</p>

Figure 3A-1 shows an example of a completed Rates Table Template when “Age-Based Rates” is selected.

Figure 3A-1. Rates Table Template (Age-Based Rates)

2018 Rates Table Template v7.1		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F. If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns. If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band. If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use. To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.		
Validate				
Finalize				
HIOS Issuer ID*	12345			
Federal TIN*	12-3456789			
Rate Effective Date*	1/1/2018			
Rate Expiration Date*	12/31/2018			
Rating Method*	Age-Based Rates			
Add Sheet				
Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
12345AB1234567	Rating Area 1	No Preference	0-14	10.00
12345AB1234567	Rating Area 1	No Preference	15	11.00
12345AB1234567	Rating Area 1	No Preference	16	12.00
12345AB1234567	Rating Area 1	No Preference	17	13.00

Figure 3A-2 shows an example of a completed Rates Table Template when “Family-Tier Rates” is selected.

Figure 3A-2. Rates Table Template (Family Tier Rates)

2018 Rates Table Template v7.1		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F. If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns. If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band. If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use. To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.				
Validate						
Finalize						
HIOS Issuer ID*	12345					
Federal TIN*	12-3456789					
Rate Effective Date*	1/1/2018					
Rate Expiration Date*	12/31/2018					
Rating Method*	Family-Tier Rates					
Add Sheet						
Plan ID*	Rating Area ID*	Individual Rate*	Couple *	Primary Subscriber and One Dependent*	Primary Subscriber and Two Dependents*	Family Tier Primary Subscriber and Three or More Dependents*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Required: Enter the rate of a family based on a single parent with one dependent	Required: Enter the rate of a family based on a single parent with two dependents	Required: Enter the rate of a family based on a single parent with three or more dependents
12345AB1234567	Rating Area 1	10.00	20.00	15.00	25.00	30.00

Once the Rates Table Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML file of the template that will need to be uploaded in the Rates section of the Rating Module in HIOS.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the Rates section of the Rating Module in HIOS. Refer to the Rating Module User Guide for details on how to complete this.

Section 3B: Business Rules

1. Introduction

In the Business Rules section, issuers must answer a series of questions that are used to calculate rates and determine if an enrollment group is eligible for coverage under a plan. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID;
2. Federal Taxpayer Identification Number (TIN); and
3. Plan IDs.

3. Quick Reference

Key Changes for 2018

- ◆ No changes for the 2018 QHP Application

Tips for the Business Rules Section

- ◆ Rules associated with individual and SHOP plans should be entered into one Business Rules Template.
- ◆ The first row of rules (Row 10) is the base set of issuer business rules, which must have blank values for the product ID and plan ID and must have data entered for all subsequent columns. This row applies to all products and plans associated with the HIOS Issuer ID, including individual, SHOP, QHP, and SADP products and plans. Products or plans with rules that differ from the base set of issuer business rules are defined at the product or plan level on the subsequent rows.

4. Detailed Section Instructions

Note for SERFF Submitters: The HIOS system allows only one set of issuer-level business rules (Row 10). If an issuer submits two templates (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different issuer-level business rules (Row 10), the last template uploaded by the state from SERFF into HIOS will apply to all plans, individual market and SHOP, unless the product or plan is listed separately. The issuer-level rules (Row 10) submitted on the first template uploaded will be overwritten by the issuer-level rules (Row 10) submitted on the second template uploaded.

To avoid problems connected with issuer-level rule overwrites, all Business Rules Template issuer-level business rules (Row 10) should be the same. Products and plans that do not adhere to the business rules described at the issuer level (Row 10) should be further described in the rows below Row 10, as described in the instructions below.

<i>Business Rules Template</i>	<i>Steps</i>
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Federal TIN	Enter the 9-digit (xx-xxxxxxx) TIN.
Product ID	For products with rules that differ from those entered in Row 10, enter the 10-character (xxxxxAxxx) HIOS-generated product ID number that identifies the product that will be associated with the rules defined in that row. <ul style="list-style-type: none">◆ If a product ID is entered, then the rules defined in that row will be applied to all plans associated with that product ID. All other plans and products will use the rules associated with either the HIOS Issuer ID in Row 10 or a different product ID rule.

Business Rules Template	Steps
	<ul style="list-style-type: none"> ◆ If no product ID is entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products.
Plan ID	<p>Enter the 14-character alphanumeric HIOS-generated plan ID (xxxxxAxxxxxx) that identifies the plan that will be associated with the rates in that row.</p> <ul style="list-style-type: none"> ◆ If a plan ID is entered, then the rules defined in that row will be applied to that plan ID only. All other plans and products will use the rules associated with the HIOS Issuer ID rule, product ID rule, or a different plan ID rule. ◆ If no plan ID is entered, then the rules for the product ID associated with that plan ID will be used for all plans. If no product ID rules were entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products and plans.
How are rates for contracts covering two or more enrollees calculated?	<p>Select one of the following two options from the drop-down menu:</p> <ul style="list-style-type: none"> ◆ There are rates specifically for couples and families (not just addition of individual rates): <ul style="list-style-type: none"> ▪ Use this selection if a QHP issuer in a state that does not permit rating for age or tobacco use, or if an individual market SADP issuer in any state. Health insurance issuers in states that require community rating must determine premiums for family coverage by using uniform family tiers and the corresponding multipliers established by the state. ▪ Note for SHOP issuers: Please do not make this selection for FF-SHOP or SP-SHOP products or plans. To display any FF-SHOP or SP-SHOP on-Marketplace plans, select the next option. This applies to QHPs and SADPs. ◆ A different rate (specifically for parties of two or more) for each enrollee is added together: <ul style="list-style-type: none"> ▪ Use this selection if a QHP issuer (except those in pure community rated states with uniform family tiers and corresponding multipliers) or a SHOP issuer. Premium rates are calculated by adding the per-member rates and providing the sum. Individual market SADP issuers may also use individual rating if allowed by the state.
What are the maximum number of underage (under 21) dependents used to quote a two-parent family?	<p>Select the maximum number of underage (under 21) dependents from the drop-down menu.</p>
What are the maximum number of underage (under 21) dependents used to quote a single parent family?	<p>Select the maximum number of children (under age 21) from the drop-down menu.</p>
Is there a maximum age for a dependent?	<p>Set the maximum age for a child for purposes of eligibility. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if selected, a pop-up will appear allowing the issuer to enter the maximum age with a default value of 21 or higher. QHP issuers must enter a minimum value of 25. SADP issuers must enter a minimum value of 21. Please note that the age entered is inclusive <i>through</i> that age. For example, a value of 25 is through age 25, up to age 26. ◆ Not Applicable—if selected, then there is no maximum age and the dependent is allowed to enroll regardless of age as long as he or she meets the other eligibility rules. ◆ Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26.¹¹

¹¹ 45 CFR 147.120.

<i>Business Rules Template</i>	<i>Steps</i>
	<ul style="list-style-type: none"> ◆ Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 21. <ul style="list-style-type: none"> ▪ Note: Maximum age for dependent applies only to the dependent relationships of Child, Adopted Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter.
What are the maximum number of children used to quote a children-only contract?	Select the maximum number of children allowed to be rated on a child-only plan.
Are domestic partners treated the same as secondary subscribers?	<p>Selection determines whether a Domestic Partner is allowed to be covered as a secondary subscriber. Please note that domestic partners are not differentiated by sex and can be same-sex or opposite-sex:</p> <ul style="list-style-type: none"> ◆ Yes—If selected, allows Domestic Partners to be considered a “two-parent household” (referred to in “What are the maximum number of underage dependents used to quote a two-parent family?”) for rating and eligibility purposes. (Note: If “Yes” is selected, indicate “Life Partner” as an allowable relationship in “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?”) ◆ No—If selected, does not allow Domestic Partners to be considered a “two-parent household” for rating and eligibility purposes. (Note: Issuers may choose to cover a Life Partner as an eligible dependent relationship in “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?” even if Domestic Partners are not treated the same as secondary subscribers. The Life Partner will not count toward a “two-parent household” for rating and eligibility purposes.)
Are same-sex partners treated the same as secondary subscribers?	<p>Selection determines whether a Same-Sex partner is covered as a secondary subscriber. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—If selected, then the primary subscriber/Same-Sex partner will be treated as a “two-parent household” (referred to in “What are the maximum number of underage dependents used to quote a two-parent family?”) for rating and eligibility purposes. (Note: If “Yes” is selected, indicate “Life Partner” as an allowable relationship in “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?”) ◆ No—If selected, then the primary subscriber/Same-Sex partner will not be treated as a “two-parent household” for rating and eligibility purposes. (Note: Issuers may choose to cover a Life Partner as an eligible dependent relationship in “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?” even if Same-Sex partners—other than spouses—are not treated the same as secondary subscribers. The Life Partner will not count toward a “two-parent household” for rating and eligibility purposes.)
How is age determined for rating and eligibility purposes?	<p>Select how age is defined to determine if a consumer is eligible for a plan rate. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Age on effective date—Return the rate based on the consumer’s age on the effective date. ◆ Age on January 1st of the effective date year—Return the rate based on the consumer’s age on January 1st of the effective date. ◆ Age on insurance date (age on birthday nearest the effective date)—Return the rate based on the consumer’s age closest to the effective date of the plan. ◆ Age on January 1st or July 1st—Return the rate based on the following: <ul style="list-style-type: none"> ◆ If the date of enrollment is before July 1st, then use the age as of January 1st. ◆ If the date of enrollment is after July 1st, then use the age as of July 1st.

Business Rules Template	Steps
	<ul style="list-style-type: none"> ◆ Market rules require QHP plans to select the first option, “Age on Effective Date,” whereas dental plans may choose from any of the four options above.¹² Please note, to be offered on-Marketplace, FF SHOP and SP SHOP SADPs should select only “Age on Effective Date.” No matter the entry, all FF SHOP and SP SHOP plans, QHPs and SADPs, will be displayed according to “Age on Effective Date.”
<p>How is tobacco status returned for subscribers and dependents?</p>	<p>Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No tobacco use for at least [x] months—If selected, a pop-up will appear asking for the number of months used to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than 6 months. Dental issuers are not subject to the look-back period.¹³ Please note that FF SHOP and SP SHOP plans will not recognize look-back periods other than 6 months. Rates will be tobacco or non-tobacco depending only on whether an enrollee indicates that he or she was an active tobacco user within the last 6 months (tobacco rate) or not an active tobacco user within the last 6 months (non-tobacco rate). In addition, if the enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used. ◆ Not Applicable—If selected, then there are no separate tobacco and non-tobacco use rates. ◆ If rates are calculated by adding up individual rates, then the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and the non-tobacco rate for individuals who qualify for the non-tobacco rate. ◆ For states that (1) do not permit rating for age or tobacco use and (2) establish uniform family tiers and corresponding multipliers, there are no separate tobacco rates for each family tier.
<p>What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?</p>	<ul style="list-style-type: none"> ◆ Select from the pop-up list which relationships are allowed to be included when returning rates and if the dependent must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of either the primary or dependent. Please note that the FF-SHOP and SP-SHOP do not differentiate between dependents who live with the primary subscriber and those who do not. ◆ Note that for the FF-SHOP and SP-SHOP, only Spouse, Adopted Child, Foster Child, Ward, Stepson or Stepdaughter, Self, Child, Life Partner and Other Relationship are accommodated. ◆ For each relationship, select “Yes” or “No” if the dependent is required to live in the same household: <ul style="list-style-type: none"> ▪ Yes—The dependent must live in the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ▪ No—The dependent may live in or outside the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. Please note that the FF-SHOP and SP-SHOP do not differentiate between dependents who reside with the primary subscriber and those who do not. ▪ Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26, regardless of support, residency, or dependency factors. ▪ QHP products and plans that cover children must select a value of “No” for whether the child dependent is required to live in the same household. This

¹² 45 CFR 147.102(a)(l)(iii).

¹³ 45 CFR 147.102(a)(l)(iv).

Business Rules Template	Steps
	<p>requirement applies for all child dependent relationships, including Child, Adopted Child, Foster Child, and Stepson or Stepdaughter.</p> <ul style="list-style-type: none"> ◆ Select the relationship “Life Partner” to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Please note that relationships are not differentiated by sex. If an individually rated plan covers Spouses and Life Partners, same-sex and opposite sex Spouses and Life Partners are covered.

A sample completed Business Rules Template is shown in Figure 3B-1.

Figure 3B-1. Sample Business Rules Template

2018 Business Rules Template v7.0		All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.				
Validate		Enter the Issuer Rule on the first row (no Product ID or Plan ID).				
Finalize		For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.				
		For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule				
HIOS Issuer ID*	12345					
TIN*	12-3456789					
Product ID	Plan ID (Standard Component)	How are rates for contracts covering two or more enrollees calculated?	What are the maximum number of under age (under 21) dependents used to quote a two parent family?	What are the maximum number of under age (under 21) dependents used to quote a single parent family?	Is there a maximum age for a dependent?	What are the maximum number of children used to quote a children-only contract?
		There are rates specifically for couples and for families (not just addition of individual rates)	2	1	Not Applicable	1

Once the Business Rules Template is completed, issuers must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click the Validate button in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button in the template. The Finalize function creates the .XML file of the template that will need to be uploaded in the Business Rules section of the Rating Module in the QHP Application System.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel .XLSM file and the finalized .XML file in the same folder.
Upload Template	Upload the saved file in the Business Rules section of the Rating Module in the QHP Application System. Refer to the Rating Module User Guide for details on how to complete this.

Appendix

This appendix contains information that indirectly affects the QHP Application.

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Appendix 1: Actuarial Value Calculator

1. Introduction

To satisfy the AV requirements of 45 CFR 156.140 and 156.420, QHP issuers must use the AV Calculator (AVC) developed and made available by HHS for the given benefit year unless the plan design is not compatible with the AVC (a unique plan design) (45 CFR 156.135). To assist with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP Application, HHS recalculates this value to validate that an issuer's plan designs meet AV requirements.¹⁴

2. Purpose

The purpose of this section is to describe how the cost-sharing information from the Plans & Benefits Template is translated into the inputs for the stand-alone AVC. This information is applicable to QHP and SADP issuers.

3. Quick Reference

Key Changes to the Plans & Benefits Template Related to the AVC¹⁵ for 2018

- ◆ The expanded bronze option has been added to the Plans & Benefits Template to align with the final 2018 Payment Notice.
- ◆ The “copay before deductible” option is renamed to “copay with deductible” in the Plans & Benefits Template.
- ◆ Issuers will be able to input copays for Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services in the Plans & Benefits Template and map to the AVC.
- ◆ The de minimus range for the AV of Bronze, Silver, Gold and Platinum plans is now -4/+2 instead of +/-2 and -4/+5 for Expanded Bronze (the de minimis variation for a silver plan variation of a single percentage point still applies). Therefore, issuers must use the Revised Final 2018 AV Calculator for calculating AV in the Plans & Benefits Template.

Tips for the AVC

- ◆ Download the revised final 2018 stand-alone AVC, which is available at: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.
- ◆ There are many underlying changes to the AVC this year. Issuers should review the User Guide found on the first tab of the AVC and the AVC methodology for information on these changes.¹⁶
- ◆ If a user is having difficulty matching AVs from the Plans & Benefits Template to the stand-alone AVC, follow the instructions in Section 5.2 on Troubleshooting.
- ◆ The AVC has been updated with an “Additional Notes” field that outputs new error messages that can be seen only in the stand-alone AVC. These notes are intended to help AVC users understand the AVC’s assumptions and provide some information on the AV calculation being run in the AVC, including how the special cost-sharing provisions are being engaged in the calculations. When an AV calculation is not returned because of an input error, please check the “Additional Notes” field for an explanation of the error.
- ◆ If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, rerun the procedure so that the AVs in the *AV Calculator Output Number* field are updated to reflect the changes.
- ◆ When unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).

¹⁴ For additional information on the AVC, see the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>

¹⁵ For an overview of the stand-alone AVC changes for 2018, please refer to the AVC User Guide at: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>

¹⁶ The AVC methodology can be found at: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>

4. About the AVC

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan CSR variations, and all limited cost-sharing plan variations. The AVC cannot be used with catastrophic or stand-alone dental plans. The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and stops running when used with a dental Plans & Benefits Template. If the Cost Share Variances worksheet contains unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique as well as the non-unique plan designs. If the stand-alone AVC returns an error for a unique plan design, resulting in a blank *AV Calculator Output Number*, the issuer does not need to address the error to validate the template, so long as the issuer's AV falls within the relevant de minimis range. While not required, CMS recommends that issuers run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that the issuers' submissions include the *AV Calculator Output Number* for plans that do not generate an error in the stand-alone AVC.

5. Detailed Section Instructions

Table A1-1. Plans & Benefits Check AV Calc Steps

<i>Check AV Calc</i>	<i>Steps</i>	
The Check AV Calc procedure on the Plans & Benefits ribbon allows the user to calculate AVs for all applicable plans.	Step 1	Select the relevant Cost Share Variances worksheet, and fill out all the cost-sharing information necessary to run the AVC.
	Step 2	Click the Check AV Calc button. The Check AV Calc procedure will prompt the user to select the file location of the stand-alone AVC.
	Step 3	<ul style="list-style-type: none"> ◆ A prompt will appear asking if the issuer would like to save the screenshots. ◆ Select "Yes" if the screenshots will be saved. Using the prompt, select the file name and location to save the output and create a copy of the AVC with worksheets that contain AV screenshots for each plan and plan variation. ◆ Select "No" if the screenshots will not be saved, and the Check AV Calc procedure will complete without creating any new files.
	Step 4	A validation message box will appear with the <i>Status/Error Messages</i> from the AVC for each plan or plan variation. The AV Calculator Output Number (Column F in the Cost Share Variances worksheet) is updated with the AV from the AVC. If an error prevented an AV from being calculated, the AV Calculator Output Number is left blank.
	Step 5	If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, the user must rerun the procedure so that the AVs in the <i>AV Calculator Output Number</i> field are updated to reflect the changes.
	Step 6	After the AVC is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template. The AVC file selected also should not have any saved output worksheets in it; otherwise, the AVC will return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the Check AV Calc procedure.
Upload Screenshot into HIOS ¹⁷	Step 7 (Optional)	<ul style="list-style-type: none"> ◆ Copy the screenshots into a Word document (HIOS does not allow Excel files as supporting documents). ◆ Upload a screenshot of the stand-alone AVC with the <i>Plan Name</i>, <i>Plan ID</i>, and <i>HIOS Issuer ID</i> fields filled in as a supporting document, and include the <i>HIOS Plan ID (Standard Component)</i> and date in the file name.

¹⁷ Issuers can use the stand-alone AVC to test plan designs, but they do not need to submit a completed stand-alone AVC or other supplemental documentation, such as a screenshot, except in scenarios described later (see Section 5.1). Instead, they submit a completed Plans & Benefits Template that includes the AVs populated by the Check AV Calc procedure.

5.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 156.135(b), the issuer application should include the Unique Plan Design Supporting Documentation and Justification. The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.

For plan designs that are calculated in accordance with 156.135(a) and do not need to use an alternative method under 156.135(b), issuers should first try to use the integrated version of the AVC for those plans before reverting to the use of the unique plan design option.

For plans compatible with the AVC, issuers must always use an actuarially justifiable process when inputting their plan designs into the AVC.¹⁸ If the AV obtained from the template is not identical to the AV obtained from the stand-alone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in appendix 1.
2. Follow the steps below on troubleshooting the AVC.
3. After following the troubleshooting steps, determine whether the user can replicate the results of the stand-alone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.
 - a. If the user cannot replicate the stand-alone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the stand-alone AVC and through the Plans & Benefits Template both fall within the relevant de minimis range for the plan's metal level or CSR variation, the user does not need to designate the plan as a unique plan design. Instead, the user shall set the *Unique Plan Design* field equal to "No" and leave the *Issuer Actuarial Value* field blank.
 - b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the stand-alone AVC does, designate that particular plan as a unique plan design by setting the *Unique Plan Design* field equal to "Yes." For this plan, complete the *Issuer Actuarial Value* field with the value from the stand-alone AVC. The AV from the stand-alone AVC must fall within the relevant de minimis range. Also, upload a screenshot of the stand-alone AVC with the *Plan Name*, *Plan ID*, and *HIOS Issuer ID* fields filled in as a supporting document and include the *Plan ID (Standard Component)* and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.
4. While many reasons issuers cannot match AVs between the Plans & Benefits Template and AVC have been eliminated, certain cases still remain. The following are two examples in which the cost-sharing input in the Plans & Benefits Template may differ from the cost-sharing input in the AVC:
 - a. One or more benefits applies a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.
 - b. One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but the issuer does not wish to split the benefits into their component parts during the coinsurance phase. The X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components. The following benefits can be split into Outpatient Facility and Outpatient Professional components: Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, Imaging (CT/PET Scans, MRIs), Speech Therapy, Occupational and Physical Therapy, Laboratory Outpatient, and Professional Services.

¹⁸ For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on actuarial value, available at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf>.

5.2 Differences between Stand-alone AV Calculator and Plans & Benefits Template

The screenshot feature, as mentioned at the start of this section allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the stand-alone AVC. When using the Check AV Calc feature in the Plans & Benefits Template, the user can select “Yes” after a prompt appears asking if the user wants to save the AVC screenshots. The user then selects the location where he or she wants the screenshots to be saved. The screenshot file can be opened and used to compare the screenshots found with the tabs with the screenshots the user has manually created in the stand-alone AVC. This side-by-side comparison can be very helpful in determining if the cost-sharing structure has been entered and applied as intended.

Table A1-2. Comparing Plans & Benefits and Stand-Alone AVC Screenshots

Create and Compare Screenshots	
Step 1	Calculate the Plan’s AV in the Stand-Alone AVC and save the screenshot.
Step 2	Calculate the Plan’s AV in the Plans & Benefits Template, and save the screenshot.
Step 3	Compare the two screenshots in Steps 1 and 2 line by line to identify the difference. The difference is what is causing the AV impact.

For example, if a plan is supposed to have a \$30 copay for Primary Care Visits, the cost sharing would be entered into the stand-alone AVC as shown in Figure A1-1. However, if the user entered the benefit cost sharing in the Plans & Benefits Template as shown in Figure A1-2, the AV from the stand-alone AVC and the AV returned from the **Check AV Calc** button in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, the issuer could open the screenshot file created by the **Check AV Calc** macro and the stand-alone AVC. Upon comparing the stand-alone AVC screenshot (Figure A1-1) and the Plans & Benefits Template Screenshot (Figure A1-3), the issuer would see that the *Subject to Deductible?* checkbox is checked in the Plans & Benefits screenshot, indicating that the copay is being applied with the deductible only in the Plans & Benefits Template. The issuer could resolve this by referring to Table A1-4, which shows how to correctly enter cost sharing to ensure that it maps from the *Primary Care Visit to Treat an Injury or Illness* field as intended.

Figure A1-1. Stand-alone AVC Screenshot

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$30.00

Figure A1-2. Example Plans & Benefits Cost Sharing

Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$30.00		Not Applicable	No Charge after deductible		100.00%

Figure A1-3. Screenshot Created by Check AV Calc

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00

6. Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefits Template into the AVC. The user does not need to perform these mappings, which take place automatically. If any of the required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error. The layout of the following instructions is intended to align to the order that the fields appear in the Plans & Benefits Template.

6.1 Metal Tier

The *Level of Coverage* selected for the plan in the Plans & Benefits Template is mapped to the *Desired Metal Tier* in the AVC.

New for 2018: Expanded Bronze Plans and De Minimis Range Change

Expanded Bronze Plans: This year the AV Calculator (AVC) includes a new option for users to indicate that the user is running an expanded bronze plan as finalized in the HHS Notice of Benefit and Payment Parameters. The expanded bronze plan option in the AVC allows the user to calculate the AV for bronze plans that meet certain requirements and, therefore, the user would be allowed to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible, or it meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2) as established at 45 CFR 156.140(c). The AVC does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. It is the responsibility of the bronze plan issuer to ensure that its bronze plan meets the requirements under this policy at 45 CFR 156.140(c) if the issuer uses the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation for such plans is -4 percentage points and +5 percentage points. Please see the AV Calculator Methodology and 2018 Notice of Benefit and Payment Parameters final rule for more information. For expanded bronze and silver plan CSR variations, the *Indicate if Plan Meets CSR or Expanded Bronze AV Standard?* checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, the *Desired Metal Tier* depends on the AV level of the variation. The *Desired Metal Tier* for silver plan variances is set equal to "Silver" for the 73 percent variation, "Gold" for the 87 percent variation, and "Platinum" for the 94 percent variation. The *Desired Metal Tier* must be set to "Bronze" for expanded bronze plans. De Minimis Range: In April, the Centers for Medicare & Medicaid Services (CMS) released a final rule, *Patient Protection and Affordable Care Act; Market Stabilization* that amends 45 CFR 156.140(c) which establishes the de minimis variation range for the AV level of coverage. Specifically, for plan years beginning on or after January 1, 2018, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is -4 percentage points and + 2 percentage points, as well as allows certain bronze plans to have to an AV of -4/+5 percentage points. The exception exists for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -4 percentage points and +5 percentage points.

6.2 Health Savings/Reimbursement Account (HSA/HRA) Options

If *HSA/HRA Employer Contribution* is equal to “Yes” in the Cost Share Variances worksheet of the Plans & Benefits Template, the *HSA/HRA Employer Contribution?* checkbox in the AVC is checked. The dollar amount entered for the *HSA/HRA Employer Contribution Amount* in the Plans & Benefits Template is mapped to the *Annual Contribution Amount* in the AVC.

Figure A1-4 shows the health savings account/health reimbursement account (HSA/HRA) input fields in the Plans & Benefits Template, and Figure A1-5 shows the corresponding input fields in the AVC.

Figure A1-4. HSA/HRA Input Fields in Plans & Benefits Template

HSA/HRA Detail		
HSA Eligible *	HSA/HRA Employer Contribution	HSA/HRA Employer Contribution Amount
Yes	Yes	\$500.00

Figure A1-5. HSA/HRA Input Fields in AVC

HSA/HRA Options	
HSA/HRA Employer Contribution?	<input checked="" type="checkbox"/>
Annual Contribution Amount:	\$500.00

6.3 Tiered Network Options

The AVC can accommodate plans using a multi-tiered, in-network plan design with up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, MOOPs, and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.¹⁹

If *Multiple In Network Tiers?* is equal to “Yes” in the Cost Sharing Variances worksheet of the Plans & Benefits Template, the *Tiered Network Plan?* checkbox in the AVC is checked. The *1st Tier Utilization* and *2nd Tier Utilization* fields in the Plans & Benefits Template are mapped to the *1st Tier Utilization* and *2nd Tier Utilization* fields in the AVC. The Plans & Benefits Template requires that all silver plan CSR and limited cost-sharing plan variations have the same *1st Tier Utilization* and *2nd Tier Utilization* as the standard plan.

The *Tiered Network Plan?* checkbox in the AVC is not related to the *Plan Type* selection in the Plans & Benefits Template. Non-point-of-service (POS) plans can have multiple in-network tiers in the Plans & Benefits Template, resulting in the *Tiered Network Option* checkbox being checked in the AVC.

Figure A1-6 shows the multi-tier input fields in the Plans & Benefits Template, and Figure A1-7 shows the corresponding input fields in the AVC.

¹⁹ For more information on this option, please refer to the AV Calculator Methodology and User Guide located in the first tab of the AVC here: <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

Figure A1-6. Multiple In-Network Tier Options in Plans & Benefits Template

Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
Yes	80%	20%

Figure A1-7. Multi-Tier Options in AVC

Tiered Network Option	
Tiered Network Plan?	<input checked="" type="checkbox"/>
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the “Not Applicable” option, issuers can now explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a *Copay—In Network (Tier 2)* and a *Coinsurance—In Network (Tier 2)* equal to “Not Applicable,” the **Check AV Calc** procedure assumes the benefit does not have tiered cost sharing and uses the *Copay—In Network (Tier 1)* and *Coinsurance—In Network (Tier 1)* values when mapping to Tier 2 in the AVC. This exception to the Tier 2 mapping applies to all fields other than MOOPs, default coinsurance, and deductibles, but for simplicity it will not be noted in the individual sections that follow.

6.4 MOOP and Deductible Values

The AV calculation uses the individual MOOP and deductible limits to calculate the AV of the plan. Therefore, individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC. The individual MOOPs and deductibles mapped to the AVC are not the family per-person MOOPs and deductibles.

Because some plans may have only combined in- and out-of-network MOOPs or deductibles, rather than separate in-network and out-of-network MOOPs or deductibles, the following logic determines which MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AVC.

The following applies if the plan does not have multiple in-network tiers:

1. If the *In Network* field is equal to a dollar value (“\$X”), the *In Network* field is used for the AVC.
2. If the *In Network* field is equal to “Not Applicable” and the *Combined In/Out of Network* field is equal to a dollar value, the *Combined In/Out of Network* field is used for the AVC.
3. If the *In Network* and *Combined In/Out of Network* fields are equal to “Not Applicable,” the Plans & Benefits Template returns an error when attempting to calculate an AV.

The following applies if the plan has multiple in-network tiers:

1. If the *In Network* and *In Network (Tier 2)* fields are equal to dollar values, the *In Network* and *In Network (Tier 2)* fields are used for the AVC.
2. If the *In Network* and *In Network (Tier 2)* fields are equal to “Not Applicable,” and the *Combined In/Out of Network* field is equal to a dollar value, the *Combined In/Out of Network* field is used for the AVC. In that case, the *Combined In/Out of Network* MOOP or deductible is mapped to the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AVC.
3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:
 - a. The *In Network* field is equal to a dollar value and the *In Network (Tier 2)* field is equal to “Not Applicable.”
 - b. The *In Network* field is equal to “Not Applicable” and the *In Network (Tier 2)* field is equal to a dollar value.

- c. The In Network, In Network (Tier 2), and Combined In/Out of Network fields are equal to “Not Applicable.”

6.4.1 Maximum Out-of-Pocket

If *Medical & Drug Maximum Out-of-Pocket Integrated?* is equal to “Yes” in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is unchecked. The following applies to integrated MOOPs:

1. The Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—In Network—Individual **or** Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 OOP Maximum in the AVC, depending on the logic above.
2. If the plan has multiple in-network tiers, the Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 2)—Individual **or** Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 OOP Maximum in the AVC.

Figure A1-8 shows the integrated medical and drug MOOP fields in the Plans & Benefits Template, and Figure A1-9 shows a corresponding example in the AVC.

Figure A1-8. MOOP for Medical and Drug EHB Benefits (Total) Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$4,000	\$4000 per person \$8000 per group			\$10,000	\$10000 per person \$20000 per group

Figure A1-9. Integrated Deductible and MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)			\$1,500.00
Coinsurance (% , Insurer's Cost Share)			70.00%
MOOP (\$)			\$4,000.00
MOOP if Separate (\$)			

If *Medical & Drug Maximum Out-of-Pocket Integrated?* is equal to “No” in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate OOP Maximum for Medical and Drug Spending?* checkbox in the AVC is checked. The following applies to separate MOOPs:

1. The Maximum Out-of-Pocket for Medical EHB Benefits—In Network—Individual **or** Maximum Out-of-Pocket for Medical EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Medical MOOP in the AVC.
2. The Maximum Out-of-Pocket for Drug EHB Benefits—In Network—Individual **or** Maximum Out-of-Pocket for Drug EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Drug MOOP in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. The Maximum Out-of-Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual **or** Maximum Out-of-Pocket for Medical EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Medical MOOP in the AVC.
 - b. The Maximum Out-of-Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual **or** Maximum Out-of-Pocket for Drug EHB Benefits—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Drug MOOP in the AVC.

Figure A1-10 shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and Figure A1-11 shows a corresponding example in the AVC.

Figure A1-10. MOOP for Medical EHB Benefits and MOOP for Drug EHB Benefits Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$3,000	\$3000 per person \$6000 per group			\$8,000	\$8000 per person \$16000 per group

Maximum Out of Pocket for Drug EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$1,000	\$1000 per person \$2000 per group			\$5,000	\$5000 per person \$10000 per group

Figure A1-11. Separate Deductible and MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$500.00	
Coinsurance (% , Insurer's Cost Share)	80.00%	80.00%	
MOOP (\$)			
MOOP if Separate (\$)	\$3,000.00	\$1,000.00	

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds \$7,600. Because the AVC can be available before the finalization of the annual limit on cost sharing for a given plan year, there is an estimated annual limit on cost sharing in the AVC to ensure that the final AVC does not contain an annual limit on cost sharing that is lower than the finalized one. For the 2018 AV Calculator, the MOOP limit and related functions have been set at \$7,600 to account for an estimated 2018 annual limitation on cost sharing. The final 2018 annual limitation on cost sharing was specified in the HHS Notice of Benefit and Payment Parameters for 2018 and is \$7,350 for self-only coverage and \$14,700 for other than self-only coverage for 2018. Issuers that are required to meet AV standards must comply with the limit established in the regulation and may not use the projected estimates stated in the 2018 AV Calculator when finalizing plan designs.

The AVC does not allow a plan to have separate MOOPs if it has an integrated medical and drug deductible. If *Medical & Drug Maximum Out-of-Pocket Integrated?* is equal to "No" and *Medical & Drug Deductibles Integrated?* is equal to "Yes" in the Plans & Benefits Template, the Plans & Benefits Template returns an error when attempting to calculate the AV.

6.4.2 Deductibles

New for 2018: If the user has a deductible greater than \$0, one service must be subject to the deductible or the AVC will return an error.

If the *Medical & Drug Deductibles Integrated?* field is equal to “Yes” in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is checked.²⁰ The following applies to integrated deductibles:

1. The Combined Medical & Drug Essential Health Benefit (EHB) Deductible—In Network—Individual **or** Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Combined Deductible in the AVC.
2. If the plan has multiple in-network tiers, the Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Individual **or** Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Combined Deductible in the AVC.

Figure A1-12 shows the integrated deductible fields in the Plans & Benefits Template, and Figure A-8 (shown earlier) displays a corresponding example in the AVC.

Figure A1-12. Combined Medical & Drug EHB Deductible Fields in Plans & Benefits Template

Combined Medical and Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person \$3000 per group	30%	\$2,000	\$2000 per person \$4000 per group	40%	\$5,000	\$5000 per person \$10000 per group	
\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	
\$1,500	\$1500 per person \$3000 per group	30%	\$2,000	\$2000 per person \$4000 per group	40%	\$5,000	\$5000 per person \$10000 per group	

If the value in the *Medical & Drug Deductibles Integrated?* field is equal to “No” in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is unchecked. The following applies to separate medical and drug deductibles:

1. The Medical EHB Deductible—In Network—Individual **or** Medical EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Medical Deductible in the AVC.
2. The Drug EHB Deductible—In Network—Individual **or** Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 1 Drug Deductible in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. The Medical EHB Deductible—In Network (Tier 2)—Individual **or** Medical EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Medical Deductible in the AVC.
 - b. The Drug EHB Deductible—In Network (Tier 2)—Individual **or** Drug EHB Deductible—Combined In/Out Network—Individual value in the Plans & Benefits Template is mapped to the Tier 2 Drug Deductible in the AVC.

²⁰ For information on the combined versus separate deductible in the AVC, please refer to the AVC User Guide located on the first tab of the AVC at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

Figure A1-13 and Figure A1-14 show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and Figure A1-15 shows a corresponding example of separate medical and drug deductibles in the AVC.

Figure A1-13. Medical EHB Deductible Fields in Plans & Benefits Template

Medical EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person \$3000 per group	20%	\$2,000	\$2000 per person \$4000 per group	30%	\$3,000	\$3000 per person \$6000 per group	
\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	
\$1,500	\$1500 per person \$3000 per group	20%	\$2,000	\$2000 per person \$4000 per group	30%	\$3,000	\$3000 per person \$6000 per group	

Figure A1-14. Drug EHB Deductible Fields in Plans & Benefits Template

Drug EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500	\$1500 per person \$3000 per group	30%	\$2,000	\$2000 per person \$4000 per group	40%	\$5,000	\$5000 per person \$10000 per group	
\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	0%	\$0	\$0 per person \$0 per group	
\$1,500	\$1500 per person \$3000 per group	30%	\$2,000	\$2000 per person \$4000 per group	40%	\$5,000	\$5000 per person \$10000 per group	

Figure A1-15. Separate Medical and Drug Deductibles and Integrated MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$1,500.00	
Coinsurance (%; Insurer's Cost Share)	80.00%	70.00%	
MOOP (\$)	\$4,000.00		
MOOP if Separate (\$)			

6.5 Default Coinsurance

While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AVC must be set equal to 1-X percent, where X percent is the coinsurance value entered in the Plans & Benefits Template. For example, if enrollees pay 10 percent of specialist visit costs, the coinsurance in the Plans & Benefits Template would be equal to 10 percent. The coinsurance in the AVC would be equal to 90 percent to represent the 90 percent of costs incurred by the issuer.

Table A1-3. Coinsurance Mapping

Coinsurance Mapping between the Plans & Benefits Template and the AVC	
Plans & Benefits (Enrollee's Cost Share)	AVC (Insurer's Cost Share)
X%	(1 - X)%
10%	90%
40%	60%

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AVC. If *Medical & Drug Deductibles Integrated?* is equal to "Yes" in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Combined Medical & Drug EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Combined Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).
2. If the plan has multiple in-network tiers, one minus the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Combined Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

Figure A1-12 (displayed earlier) shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and Figure A1-15 (displayed earlier) shows an example in the AVC.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AVC. If *Medical & Drug Deductibles Integrated?* is equal to “No” in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Medical EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Medical Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).
2. One minus the *Drug EHB Deductible—In Network—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 1 Drug Coinsurance* in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. One minus the *Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Medical Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).
 - b. One minus the *Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* value in the Plans & Benefits Template is mapped to the default *Tier 2 Drug Coinsurance* in the AVC.

6.6 Subject to Deductible?

New for 2018: The cost sharing option of “Copay before Deductible” is replaced with “Copay with Deductible”. The copay and coinsurance qualifiers in the Plans & Benefits Template determine whether the *Subject to Deductible?* checkbox in the AVC is checked (see Figure A1-16 and Figure A1-17). For each benefit, if either the *Copay—In Network (Tier 1)* or the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template contains the text “with deductible” or “after deductible,” the *Tier 1 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers (the plan has multiple tiers and both *Copay—In Network (Tier 2)* and *Coinsurance—In Network (Tier 2)* are not equal to “Not Applicable”), the same logic applies to Tier 2.

Figure A1-16. Fields in Plans & Benefits Template Mapping to *Subject to Deductible?* Fields in AVC

Primary Care Visit to Treat an Injury or Illness						Specialist Visit					
Copay			Coinsurance			Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$20.00	\$25.00	\$40.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	10.00% Coinsurance after deductible	20.00% Coinsurance after deductible	40.00% Coinsurance after deductible

Figure A1-17. Benefit Categories in AVC

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

Table A1-4 shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AVC—including the *Subject to Deductible?* logic—for all benefits other than mental health and substance abuse benefits. For mental health and substance abuse benefits, see Table A1-6. Section 6.11.5 describes the copay and coinsurance mappings in more detail.

Table A1-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible ?	Subject to Coinsurance ?	Coinsurance	Copay	Copay applies only after deductible ?
\$X Copay after deductible \$X Copay per Day after deductible, \$X Copay per Stay after deductible, OR No Charge after deductible	X% OR X% Coinsurance after deductible	Checked	Checked	(1-X)%	Blank	Unchecked
No Charge OR Not Applicable	X% Coinsurance after deductible					
\$X, \$X Copay per Day, OR \$X Copay per Stay	X% Coinsurance after deductible	Checked	Checked	(1-X)%	\$X	Unchecked
\$X Copay with deductible, \$X Copay per Day with deductible, OR \$X Copay per Stay with deductible	X% OR X% Coinsurance after deductible					

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible ?	Subject to Coinsurance ?	Coinsurance	Copay	Copay applies only after deductible ?
No Charge OR Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge OR Not Applicable					
No Charge after deductible	No Charge after deductible					
\$X Copay after deductible, \$X Copay per Day after deductible, OR \$X Copay per Stay after deductible	No Charge, Not Applicable, OR No Charge after deductible	Checked	Unchecked	Blank	\$X	Checked
\$X, \$X Copay per Day, OR \$X Copay per Stay	No Charge after deductible	Checked	Unchecked	Blank	\$X	Unchecked
\$X Copay with deductible, \$X Copay per Day with deductible, OR \$X Copay per Stay with deductible	No Charge, Not Applicable, OR No Charge after deductible					
No Charge, OR Not Applicable	X%	Unchecked	Checked	(1-X)%	Blank	Unchecked
\$X, \$X Copay per Day, OR \$X Copay per Stay	X%	Unchecked	Checked	(1-X)%	\$X	Unchecked
No Charge OR Not Applicable	No Charge OR Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X, \$X Copay per Day, OR \$X Copay per Stay	No Charge OR Not Applicable	Unchecked	Unchecked	Blank	\$X	Unchecked

6.7 Subject to Coinsurance?

For each benefit, if *Coinsurance—In Network (Tier 1)* is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked. For a plan with multiple in-network tiers, if *Coinsurance—In Network (Tier 2)* is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the *Tier 2 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked.

6.8 Different Coinsurance Values

A coinsurance value for a benefit category is mapped to the AVC only if the coinsurance for the given benefit differs from the relevant default coinsurance. For each benefit, if the *Tier 1 Subject to Coinsurance?* checkbox in the AVC is checked as described above, one minus X percent, where X percent is the coinsurance value from the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template, is mapped to the *Tier 1 Coinsurance, if different* field for the corresponding benefit in the AVC. For a benefit with multiple in-network tiers, if the *Tier 2 Subject to Coinsurance?* checkbox in the AVC is checked, one minus X percent, where X percent is the coinsurance value from the *Coinsurance—In Network (Tier 2)* field, is mapped to the *Tier 2 Coinsurance, if different* field for the corresponding benefit in the AVC.

The AVC functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AVC User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.²¹

The AVC treats “No Charge” (or “Not Applicable”) and “0%” coinsurance differently when a benefit’s copay is greater than “\$0.” If the benefit has coinsurance equal to “No Charge” (or “Not Applicable”) and a copay greater than “\$0,” the relevant *Subject to Coinsurance?* checkbox in the AVC is unchecked, and the AVC assumes that the enrollee pays a copay until reaching the MOOP. If the benefit has a coinsurance equal to “0%” and a copay greater than “\$0,” the relevant *Subject to Coinsurance?* checkbox in the AVC is checked and “100%” is entered into the relevant *Coinsurance, if different* field in the AVC. In the latter case, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing.

6.9 Copay Values

For each benefit, if *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to “\$X,” “\$X Copay with deductible,” “\$X Copay per day,” “\$X Copay per stay,” “\$X Copay per stay with deductible,” or “\$X Copay per day with deductible,” the *Tier 1 Copay, if separate* field in the AVC is set equal to X. If *Copay—In Network (Tier 1)* is equal to “\$X Copay after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and the corresponding *Coinsurance—In Network (Tier 1)* field is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable,” the *Tier 1 Copay, if separate* field in the AVC is set equal to X. If *Copay—In Network (Tier 1)* is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable,” the *Tier 1 Copay, if separate* field in the AVC is left blank.

When both coinsurance and copay values are present for a given benefit, the AVC can consider a copay in the deductible range and a coinsurance rate in the coinsurance range; however, the stand-alone AVC does not support applying both a copay and a coinsurance in the coinsurance range. If a benefit’s copay is only after deductible and before the MOOP, and the benefit also has a coinsurance, the AVC considers only the coinsurance value in the coinsurance range. Therefore, if *Copay—In Network (Tier 1)* is equal to “\$X Copay after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and *Coinsurance—In Network (Tier 1)* is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the *Tier 1 Copay, if separate* field in the AVC is left blank. For benefits with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

As discussed in the AV Calculator Methodology and User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services; Imaging; Speech Therapy; Occupational Therapy and Physical Therapy; and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient - Facility and/or Outpatient - Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility and Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AV Calculator also allows the user to indicate the cost sharing for Primary Care and/or Specialist Office Visits and X-rays. The stand alone AV Calculator will indicate if the special cost sharing was engaged in the AV calculation in the Additional Notes field. For additional information on the operations of these features, review the AV Calculator Methodology and User Guide.

6.10 Copay Applies Only After Deductible

For each benefit, if the *Copay—In Network (Tier 1)* is equal to “\$X after deductible,” “\$X Copay per stay after deductible,” or “\$X Copay per day after deductible” and the *Coinsurance—In Network (Tier 1)* is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template, the *Tier 1 Copay applies only after the deductible?* checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. While the AVC returns an error if the *Copay applies*

²¹ The AVC User Guide can be found on the first tab of the AVC located at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>. The appendix at the end of the User Guide contains charts that provide detail and examples regarding the application of cost sharing within the deductible and coinsurance range.

only after the deductible? checkbox is checked and the benefit is also subject to a coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

6.11 Benefit Categories²²

Table A1-5 shows the alignment of benefit categories in the Plans & Benefits Template and the AVC, and Figure A1-17 (shown earlier) displays the benefit categories, along with their cost-sharing fields, in the AVC.

If a benefit included in the AVC is substituted in the Plans & Benefits Template, the benefit is considered not covered for purposes of mapping to the AVC. When a benefit is not covered, the *Coinsurance, if different* field for the benefit in the AVC is set to “0%,” and the *Subject to Coinsurance?* and *Subject to Deductible?* checkboxes are checked.

No inputs into the AVC are specific to the pediatric dental or vision benefits. Pediatric dental and vision are generally low-cost benefits that do not have a material impact on AV. Additional information on how pediatric dental and vision benefits are taken into account in the AVC is available in the AVC methodology.

Table A1-5. Benefit Category Alignment between Plans & Benefits Template and AVC

Plans & Benefits Template category name	AVC category name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., Hospital Stay)	All Inpatient Hospital Services (inc. MHSA)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (exc. Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy
Preventive Care/Screening/Immunization ²³	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs

²² The 2018 AVC uses new claims data from 2015 projected forward to 2018. For information about the considerations of the new claims data, please refer to the AV Calculator Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

²³ Section 2713 of the Public Health Service Act, codified in 45 CFR 147.130, requires issuers to offer certain preventive care services without cost sharing, so the stand-alone AVC automatically takes into account no cost sharing for these services in the AV calculation and does not allow users to enter cost sharing for the Preventive Care/Screening/Immunization benefit category. Thus, regardless of the cost sharing in the Preventive Care/Screening/Immunization benefit category in the Plans & Benefits Template, no mapping occurs between the Plans & Benefits Template and the stand-alone AVC for this benefit category.

Table A1-5. Benefit Category Alignment between Plans & Benefits Template and AVC

Plans & Benefits Template category name	AVC category name
Specialty Drugs	Specialty Drugs (high-cost)

6.11.1 Inpatient Hospital Services

New for 2018: The AV Calculator will return an error if the user uses the *Maximum Number of Days for Charging an Inpatient Copay* feature and does not check *Apply Inpatient Copay per Day?*

If the Inpatient Hospital Services *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to “\$X Copay per Day,” “\$X Copay per day with deductible,” or “\$X Copay per day after deductible,” the *Apply Inpatient Copay per Day?* checkbox in the AVC is checked. If the Inpatient Hospital Services copay is charged per day for Tier 1, the AVC automatically assumes that the Inpatient Hospital Services copay is also charged per day for Tier 2, if applicable.

If *Maximum Number of Days for Charging an Inpatient Copay?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Set a Maximum Number of Days for Charging an In Patient (IP) Copay?* checkbox in the AVC is checked, and the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template is mapped to *# Days (1–10)* in the AVC. If the *Maximum Number of Days for Charging an Inpatient Copay?* field is blank in the Plans & Benefits Template, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AVC is unchecked and *# Days (1–10)* in the AVC is left blank.

The *Maximum Number of Days for Charging an Inpatient Copay?* field is set at the plan variation level, allowing the values to differ between variations. However, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox and the *# Days (1–10)* field cannot vary between Tier 1 and Tier 2. Figure A1-18 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template, and Figure A1-19 shows the corresponding checkbox and field in the AVC.

When filling out the stand-alone AVC, issuers intending to use the *Maximum Number of Days for Charging an Inpatient Copay* feature need to ensure that the *Apply Inpatient Copay per Day?* checkbox at the AVC (Figure A1-20) is checked. Otherwise the AVC will return an error when trying to calculate the AV. On the Benefits and Templates side, the user needs to follow the instruction in the first paragraph and select a cost sharing option that includes “per day” in order to ensure the “*Apply Inpatient Copay per Day?*” checkbox is checked in the AV Calculator mapping.

Figure A1-18. AVC Additional Benefit Design Fields in Plans & Benefits Template

AV Calculator Additional Benefit Design			
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?
\$200	5	3	

Figure A1-19. Maximum Number of Days for IP Copay Checkbox and Field in AVC

Set a Maximum Number of Days for Charging an IP Copay?	<input checked="" type="checkbox"/>
# Days (1-10):	5

Figure A1-20. Apply IP Copay Checkbox in AVC

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>
Apply Inpatient Copay per Day?	<input checked="" type="checkbox"/>
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	<input type="checkbox"/>
Desired Metal Tier	Silver <input type="button" value="v"/>

6.11.2 Skilled Nursing Facility

If the Skilled Nursing Facility *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to “\$X Copay per Day,” “\$X Copay per day with deductible,” or “\$X Copay per day after deductible,” the *Apply Skilled Nursing Facility Copay per Day?* checkbox in the AVC is checked. If the Skilled Nursing Facility copay is charged per day for Tier 1, the AVC automatically assumes that the Skilled Nursing Facility copay is also charged per day for Tier 2, if applicable.

Users intending to charge a Skilled Nursing Facility Copay per day should ensure that they have selected the *Apply Skilled Nursing Facility Copay per Day?* checkbox while filling out the stand-alone AVC to ensure accuracy of AV calculations.

6.11.3 Primary Care

New for 2018: The AV Calculator will return an error if the user uses *Begin Primary Care Cost-Sharing After a Set Number of Visits?* feature and does not subject primary care to the deductible.

If *Begin Primary Care Cost-Sharing After a Set Number of Visits?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is checked, and the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field in the Plans & Benefits Template is mapped to # *Visits (1–10)* in the AVC. If the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field is blank in the Plans & Benefits Template, then the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is unchecked and # *Visits (1–10)* in the AVC is left blank. As discussed in the AV Calculator User Guide, the use of this option does not imply a benefit design for primary care visits after the initial fully covered visits have occurred. The user must still indicate whether or not primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost-sharing (such as deductible and coinsurance) in the Plans & Benefits Template under the “*Primary Care Visit to Treat an Injury or Illness.*”

If *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is checked and the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field in the Plans & Benefits Template is mapped to # *Copays (1–10)* in the AVC. If the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field is blank in the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is unchecked and # *Copays (1–10)* in the AVC is left blank. Per the AV Calculator User Guide, the use of this option does not imply a benefit design for primary care visits after the initial copays have occurred. The user must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under the “*Primary Care Visit to Treat an Injury or Illness.*”

The *Begin Primary Care Cost-Sharing After a Set Number of Visits?* and *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* fields (Figure A1-21) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (Figure A1-21) cannot vary between Tier 1 and Tier 2. In addition to inputting any copay amount, these options must be used in conjunction with the *Subject to Deductible?* option for primary care services. Unchecking *Subject to Deductible?* with this option will result in an error message.

Figure A1-21. Primary Care Options in AVC

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	<input checked="" type="checkbox"/>
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
52	# Copays (1-10):	

6.11.4 Outpatient Facility Fee and Surgery Physician/Surgical Services

This year the AVC has been updated to allow for copay values for the Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services benefit categories.

6.11.5 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services copay and coinsurance inputs are weighted averages of the Mental/Behavioral Health Outpatient Services and the Substance Abuse Disorder Outpatient Services cost-sharing fields in the Plans & Benefits Template. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the Mental/Behavioral Health Outpatient Services benefit in the Plans & Benefits Template when mapping to the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services *Subject to Deductible?*, *Subject to Coinsurance?*, and *Copay applies only after the deductible?* checkboxes in the AVC. The copay and coinsurance values for the Substance Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AVC checkboxes.

If either the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* or *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* fields in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services *Tier 1 Subject to Deductible?* checkbox in the AVC is checked.

If the *Mental/Behavioral Health Outpatient Services Coinsurance—In Network (Tier 1)* is equal to “X% Coinsurance after deductible” or “X%” in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked. Then, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)})]$ is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC.

In the following two scenarios, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)})]$ is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC:

1. When the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to “\$X” or “\$X with deductible” in the Plans & Benefits Template.
2. When the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to “\$X after deductible” and the *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template.

If the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to “\$X after deductible” and the *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to “No Charge,” “No Charge after deductible,” or “Not Applicable” in the Plans & Benefits Template, the *Tier 1 Copay applies only after the deductible?* checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in Table A-2) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the

Tier 2 copay and Tier 2 coinsurance are equal to “Not Applicable.” If *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to “Not Applicable,” the **Check AV Calc** procedure will use the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC. If *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to “Not Applicable,” the **Check AV Calc** procedure will use the *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)* values for Substance Abuse Disorder Outpatient Services when mapping to the *Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 2* fields in the AVC.

Table A1-6 shows the detailed mappings described in this section.

Table A1-6. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template— Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay after deductible OR No Charge after deductible	X% OR X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
No Charge OR Not Applicable	X% Coinsurance after deductible					
\$X	X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	X% OR X% Coinsurance after deductible					
No Charge OR Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge, Not Applicable, OR No Charge after deductible					
\$X Copay after deductible	No Charge, Not Applicable, OR No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked
\$X	No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	No Charge, Not Applicable, OR No Charge after deductible					
No Charge, OR Not Applicable	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
\$X	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
No Charge OR Not Applicable	No Charge OR Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X	No Charge OR Not Applicable	Unchecked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked

6.11.6 Drugs

The Plans & Benefits Template and the AVC require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs.

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay, enter “No Charge,” “No Charge after the deductible,” or “Not Applicable” rather than “0%” or “0% Coinsurance after deductible” in the *Coinsurance—In Network (Tier 1)* or *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template to avoid an error from the AVC. Likewise, if a drug benefit has only a coinsurance, enter “No Charge,” “No Charge after the deductible,” or “Not Applicable” rather than “\$0” or “\$0 Copay after deductible” in the *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* fields in the Plans & Benefits Template.

6.11.6.1 Specialty Drugs

If the *Maximum Coinsurance for Specialty Drugs* field includes a positive number in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is checked, and the *Maximum Coinsurance for Specialty Drugs* field in the Plans & Benefits Template is mapped to the *Specialty Rx Coinsurance Maximum* field in the AVC. If the *Maximum Coinsurance for Specialty Drugs* field is blank in the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is unchecked, and the *Specialty Rx Coinsurance Maximum* field in the AVC is left blank.

The *Maximum Coinsurance for Specialty Drugs* field (Figure A1-22) is set at the plan variation level, allowing the values to differ between variations. However, the specialty drugs maximum coinsurance checkbox and amount field (Figure A1-22) cannot vary between Tier 1 and Tier 2.

Figure A1-22. Specialty Drugs Maximum Payment Fields in AVC

Set a Maximum on Specialty Rx Coinsurance Payments?	<input checked="" type="checkbox"/>
Specialty Rx Coinsurance Maximum:	\$200

7. Zero Cost Sharing and Limited Cost Sharing Plan Variations

Zero cost sharing plan variations, which are required to have zero cost sharing for all EHB categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee’s costs. Limited cost-sharing plan variations, which are required to have the same cost sharing and MOOPs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost-sharing plan variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral under contract health services (45 CFR 156.420[b][2]), these CSRs are not represented in the Plans & Benefits Template and are not included in the AV calculation.

Appendix 2: Plan ID Crosswalk

1. Introduction

The Plan ID Crosswalk template crosswalks PY2017 QHP standard component ID and service area combinations (e.g., Plan ID and County combinations) to a PY2018 QHP Plan ID. This data will facilitate 834 enrollment transactions from CMS to the issuer for those enrollees in the individual market who have not actively selected a different QHP during open enrollment. These instructions apply to QHP and SADP issuers that offered Individual market QHPs on the exchange during PY2017.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID;
2. Issuer State;
3. Market Coverage;
4. Completed Plans & Benefit template;
5. Completed Service Area template;
6. A determination of whether the 2018 QHP duplicates Medicare; and
7. A determination of whether enrollment in the 2018 QHP is a change in policy or contract for 2017 QHP enrollees

3. Quick Reference

Key Changes for 2018

- ◆ The template includes validations that evaluate whether the 2018 QHP duplicates Medicare and is a change of policy or contract

Tips for the Plan ID Crosswalk

- ◆ First-time QHP issuers are not expected to submit a Plan ID Crosswalk template
- ◆ For PY2018, CMS has deferred the FF-SHOPs ability auto renew employees. Therefore, issuers should not attempt to submit a Plan ID Crosswalk template for FF-SHOP plans.
- ◆ Issuers need to submit the Plan ID Crosswalk template to the following email:
QHP_Applications@cms.hhs.gov.
- ◆ You must import only one Plans & Benefits template and one Service Area template. You must make separate submissions for MSP and SADP Plans.

4. State Authorization of the Plan ID Crosswalk Template

Issuers are expected to submit evidence from the state, such as an email confirmation, that the issuer is authorized to submit its Plan ID Crosswalk template. CMS will require this evidence to be submitted by issuers no later than June 21, 2017. Any subsequent submission of an issuer's Plan ID Crosswalk template after June 21st should include an updated state authorization form. Issuers should provide evidence of state authorization to QHP_Applications@cms.hhs.gov.

States have the opportunity to review the Plan ID Crosswalk Template for overall approval and compliance with the Affordable Care Act market reforms such as uniform modification of coverage standards. States have flexibility to determine the exact method by which they will review the Plan ID Crosswalk template. For example, a state may perform a detailed review to confirm that the submitted Plan ID Crosswalk template is consistent with state and federal requirements and reflects what the state expects to see in relation to their form filing reviews.

CMS will not send Plan ID Crosswalk templates to states. Issuers may be asked by their state regulators to provide this template in addition to their submission to CMS (e.g., include the template as part of the NAIC SERFF binder).

Issuers in Direct Enforcement states (Missouri, Oklahoma, Texas, and Wyoming) should submit the authorization form to their state Department of Insurance and to CMS' Compliance and Enforcement Division (formfiling@cms.hhs.gov) to obtain the necessary authorization for submission.

5. Detailed Section Instructions

Perform the following steps to complete the Plan ID Crosswalk template.

To complete the information on the 2017 Plan Crosswalk tab, follow the steps in the table below.

2017 Plan Crosswalk Tab	Steps
Import 2017 Plans & Benefits and Service Area Template	<p>Click the Import 2017 Plans & Benefits and Service Area Template button. This action imports the completed templates.</p> <p>The template will prompt you to select your completed 2017 Plans & Benefits template and 2017 Service Area template. The Plans & Benefits and Service Area templates must be selected at the same time; therefore both templates should be saved in the same folder prior to importing. To select both files, click on one template, and then press the Ctrl button while clicking on the other template, then click Open. You must select exactly one Plans & Benefits template and one Service Area template.</p> <p>The Crosswalk template will populate a list of PY2017 Plan IDs and their associated service areas on the 2017 Plan and Service Area Data tab. Review this tab to ensure the data was accurately imported. After the PY2017 plan and service area data has been imported, the 2017 Plan Crosswalk tab will be populated with all applicable issuer information as well as a row for each PY2017 Plan ID.</p>
HIOS Issuer ID	Ensure the template has accurately populated the five-digit HIOS Issuer ID.
Issuer State	Ensure the template has accurately populated the state in which the issuer is offering coverage.
Market Coverage	<p>Ensure the template has accurately populated the market coverage from the drop-down menu.</p> <p>The FF-SHOP Marketplace will not allow auto-renewals for PY2018. Because of this, this field will be hard coded to <i>Individual</i>.</p>
Dental Only	<p>Ensure the template accurately indicates whether this Crosswalk template is for dental only plans. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—This template is for stand-alone dental plans (SADP) only. ◆ No—This Plan ID Crosswalk is for QHP plans.
Multi-State Plan	<p>Choose from the dropdown to indicate whether this crosswalk template is for OPM Multi-State Plans or not. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—This Plan ID Crosswalk is for the issuer's Multi-State Plans. ◆ No—This Plan ID Crosswalk is for the issuer's non-Multi-State Plans.

2017 Plan Crosswalk Tab	Steps
Crosswalk Level	<p>Select from the dropdown menu the level at which you would like to crosswalk your PY2017 plan. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Crosswalking to the Same Plan ID: Select this option if you are crosswalking your PY2017 plan to the same Plan ID for PY2018 and you have no service area changes. ◆ Crosswalking at the Plan ID Level: Select this option if you have no service area changes but are using a different PY2018 Plan ID to reflect the same plan. ◆ Crosswalking at the Plan ID and county coverage level: Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2017 plan to two or more PY2018 Plan IDs. Note: If your PY2017 plan covered the entire state, you will need to crosswalk the plan for every county in the state. ◆ Crosswalking at the zip level for one or more counties: Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2017 plan to two or more PY2018 Plan IDs for the same county. Selecting this option will require you to select the counties from the PY2017 plan's service area that will be crosswalked at the zip code level. The remaining PY2017 service area will be crosswalked at the county level. Note: CMS discourages issuers from crosswalking at the zip level unless absolutely necessary. ◆ Discontinue with no crosswalk: Select this option if you are discontinuing a PY2017 plan with no re-enrollment option for its enrollees. ◆ Plan withdrawn prior to Certification: Select this option if the PY2017 plan was withdrawn from the Marketplace prior to certification and has no enrollment. Issuers should also select this option if the PY2017 Plan ID listed on the Template was not approved by the state or FFM to be offered on the Marketplace in PY2017.
Counties Crosswalked at Zip Level	Select from the pop-up menu which counties in your PY2017 plan's service area will be crosswalked at the zip code level.

To complete the information on the 2018 Plan Crosswalk tab, follow the steps in the table below.

2018 Plan Crosswalk Tab	Steps
Create "2018 Crosswalk Tab"	<p>Click the Create "2018 Crosswalk Tab" button. This action creates one 2018 Plan Crosswalk tab.</p> <p>The first four columns, <i>2017 HIOS Plan ID</i>, <i>County Name</i>, <i>Service Area Zip Codes</i>, and <i>Crosswalk Level</i> will be auto-populated based on your entries in the 2018 Plan Crosswalk tab. If you decided to crosswalk at the Plan ID-County level for one or more plans, a row will appear for each county that plan covered in PY2017. If the user decided to crosswalk at the zip level for specific counties covered by a PY2017 plan, a row for each Plan ID-County-Zip code combination will appear.</p> <p>Only click this button when you are sure the 2017 Plan Crosswalk tab is complete. If you want to make changes on this tab after the 2018 Plan Crosswalk tab is created, you will need to click the Create 2018 Crosswalk Tab button again and start over on the 2018 Plan Crosswalk tab. Clicking the Create 2018 Crosswalk Tab button will clear all data you have already entered on the 2018 Plan Crosswalk tab, so copy and paste this information into a separate workbook if you want to save your previous work.</p>

Crosswalk Reason	<p>Choose from the dropdown menu the reason for the crosswalk. The list of options will depend upon the Crosswalk Level selected. Table 2A-1 lists the possible Crosswalk Reason entries for each Crosswalk Level:</p> <ul style="list-style-type: none"> ◆ Renewing exact same product/plan combination (Same PY2017 Plan ID): Select this option if you are crosswalking this Plan ID/Service Area to the exact same HIOS Plan ID. Under this option, the template will auto-populate the PY2018 Plan ID field with your PY2017 Plan ID. Issuers are expected to comply with the “same plan” standards as defined in 45 CFR § 144.103. Issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2018 plan year. ◆ Renewing exact same product/plan combination (Different 2017 Plan ID): Select this option if you are crosswalking this Plan ID/Service Area to the same product/plan combination but with a different PY2018 Plan ID. Issuers are expected to comply with the “same plan” standards as defined in 45 CFR § 144.103. As stated above, in most cases, issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming PY2018. <ul style="list-style-type: none"> ▪ In the limited cases where an issuer is continuing the same plan but has a need to crosswalk to a different HIOS Plan ID, the issuer should seek guidance and approval from their state regulatory authority prior to submitting their Plan ID Crosswalk template to CMS. In the case of MSP options, an issuer should contact OPM for guidance and prior approval. ◆ Renewing product: renewal in a different plan within product: Select this option if you are renewing this product, but crosswalking this Plan ID/Service Area to a different plan within the product offered through the FFM. If you select this option, you must use the same product ID embedded in the plan’s 2017 Plan ID. ◆ Continuing product: no plan available in the particular service area under that product; enrollment in a different product: Select this option if you are continuing this product in PY2018 but will no longer offer any plans in part of the service area covered by the product in PY2017 and are crosswalking to a plan within a different product offered through the FFM. Select this reason for that portion of the service area that you no longer offer any plans under that product. If you select this option, you must crosswalk to a PY2018 Plan ID with a different product ID from the PY2017 Plan ID. ◆ Continuing product: no plan available in the particular service area under that product; no enrollment option: Select this option if you are continuing a PY2017 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Issuers should not enroll pertinent plans into a plan offered outside the Marketplace. Selecting this option will disable the 2018 HIOS Plan ID field. ◆ Continuing product: no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product: Select this option if there is no available silver plan within the enrollee’s product in a particular service area and the enrollee is being enrolled in a silver plan within another product. ◆ Discontinuing product: enrollment into a different product: Select this option if this PY2017 product is discontinued for PY2018 and enrollees in this plan and associated service area will be re-enrolled in a plan under a different product offered through the FFM. Under this option, the entered PY2018 Plan ID must have a different Product ID and you may not enter the discontinued PY2017 product ID for any other row under the PY2018 Plan ID. ◆ Discontinuing product: no enrollment option: Select this option if a PY2017 product is discontinued for PY2018 and there is no enrollment option through the FFM for PY2017 enrollees in this Plan ID/Service Area combination. Issuers
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2018 Plan Crosswalk Tab	Steps
	should not enroll pertinent plans into a plan offered outside the Marketplace. Selecting this option will disable the PY2018 Plan ID field. Under this option, you may not enter the discontinued PY2017 product ID for any other row under the PY2018 Plan ID.
2018 HIOS Plan ID	Enter the PY2018 Plan ID you would like to crosswalk your enrollees to for the row's PY2017 Plan ID/Service Area. This field will be auto-populated when "Renewing exact same product/plan combination (Same 2017 Plan ID)" is chosen under the <i>Crosswalk Reason</i> . This field will be disabled when "Discontinuing product; no enrollment option," "Continuing product; no plan available in the particular service area under than product; no enrollment option," is chosen under the <i>Crosswalk Reason</i> . Note: Issuers should only input PY2018 Plan IDs for plans that will be offered through the Marketplace and are listed in the 2018 QHP Application. CMS will not accept any PY2018 Plan IDs for plans only sold outside the Marketplace.
Is this PY2017 Plan a Catastrophic or Child-Only Plan?	This field will default to "No." Please select Yes for any Catastrophic or Child-Only Plan being crosswalked.
PY2018 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan	If selecting "Yes" in the previous data element, this field will allow you to enter a PY2018 Plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2018 Plan ID entered in this field.
Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s)	CMS has included the following optional data fields to be completed if requested by an issuer's state regulator: <ul style="list-style-type: none"> ◆ PY2017 Plan ID - Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s). ◆ PY2018 Plan ID - Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s). ◆ PY2018 Plan ID (Catastrophic or Child-Only) - Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s).
Are you prohibited from selling or issuing the 2018 QHP to someone enrolled in Medicare as set forth in Section 1882(d) of the Social Security Act?	Yes or No response. Consistent with the longstanding prohibitions on the sale and issuance of duplicate coverage to Medicare beneficiaries (section 1882(d) of the Social Security Act), it is illegal to knowingly sell or issue an Individual Marketplace Qualified Health Plan (or an individual market policy outside the Marketplace) to a Medicare beneficiary. If you have questions about how to answer this question, check with your legal counsel. Collection of issuer responses by CMS does not relieve issuers of their obligations under section 1882(d) of the Social Security Act.
Does reenrollment in the 2018 QHP represent an enrollment into a new policy or contract under state law for enrollees in the 2017 QHP?	Yes or No response. Is reenrollment of 2017 QHP enrollees in the 2018 QHP an enrollment into a new policy or contract under state law? If you have questions about how to answer this question, check with your legal counsel. Collection of issuer responses by CMS does not relieve issuers of their obligations under section 1882(d) of the Social Security Act.

A sample completed Plan ID Crosswalk template looks like Figure 2A-1.

Figure A2-1. Sample Plan ID Crosswalk Template

Plan Crosswalk Template 2.1.0

Issuer Information

HIOS Issuer ID*	12345
Issuer State*	VA
Market Coverage*	Individual
Dental Only Plan*	No
Multi-State Plan*	Yes

2017 HIOS Plan ID (Standard Component)	Crosswalk Level	Counties Crosswalked at Zip Level
Required	Required: Indicate whether you would like to crosswalk your 2017 to 2018 Plan IDs at the plan, county or zip code level.	Required if user indicates Crosswalked at the Zip Level for one or more counties.
12345VA0010001	Crosswalking to same Plan ID	
12345VA0010002	Crosswalking at the plan ID level	
12345VA0010003	Crosswalking at the Plan ID and county coverage level	

Actions

- Import 2017 Plan and Benefits Template and Service Area Template**
Please save your completed 2017 Plans and Benefits and Service Area Template to a folder on your harddrive.
- Create "2018 Crosswalk Tab"**
Create the "2018 Crosswalk Tab" based upon your entry below.
- Validate Data**
Validate information entered into all tabs. *Warning: Depending on data size, validation may take several minutes.*
- Finalize Template**
Export Data to XML file.

2017 Plan Crosswalk | 2017 Plan and Service Area Data

2017 HIOS PlanID (Standard Component)	County Name	Service Area Zip Code(s)	Crosswalk Level	Reason for Crosswalk	CROSSWALK PLAN 2018 HIOS PlanID (Standard Component)	Is this Plan a Catastrophic or Child-Only Plan?
Required	Required if crosswalking at county or zip level	Required if crosswalking at the zip level	Based on Option Selected on "2016 Plan Crosswalk" Worksheet	Required	Required	Required
12345VA0010001			Crosswalking to same Plan ID	Renewing exact same product/plan combination (Same 2017 Plan ID)	12345VA0010001	No
12345VA0010002			Crosswalking at the plan ID level			No
12345VA0010003			Crosswalking at the Plan ID and county coverage level			No

2017 Plan Crosswalk | 2018 Plan Crosswalk | 2017 Plan and Service Area Data

Table A2-1 lists the Crosswalk Reason and PY 2018 Plan ID entry options for each Crosswalk Level.

Table A2-1. Crosswalk Level, Reason for Crosswalk, and PY2018 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2018 HIOS Plan ID
Crosswalking to same Plan ID	Renewing exact same product/plan combination (Same PY2017 Plan ID). <i>(auto-populated)</i>	Template populates field with PY2017 Plan ID. <i>(auto-populated)</i>
Crosswalking at the Plan ID Level	Renewing exact same product/plan combination (Different PY 2018 Plan ID).	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2017 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2017 Plan ID.

Crosswalk Level	Crosswalk Reason	2018 HIOS Plan ID
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2018 Plan ID.
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2017 Plan ID.
Crosswalking at the Plan ID and county coverage level	Renewing exact same product/plan combination. (Same 2017 Plan ID)	Template populates field with PY 2017 Plan ID. (<i>auto-populated</i>)
	Renewing exact same product/plan combination. (Different 2018 Plan ID)	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2017 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2017 Plan ID.
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2018 Plan ID.
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. (<i>auto-populated</i>)
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2017 Plan ID.
	Discontinuing product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. (<i>auto-populated</i>)
Crosswalking at the zip level for one or more counties	Renewing exact same product/plan combination (Same 2017 Plan ID).	Template populates field with PY2017 Plan ID. (<i>auto-populated</i>)
	Renewing exact same product/plan combination. (Different 2018 Plan ID)	Different Plan ID
	Renewing product; renewal in a different plan within product.	Plan ID with same Product ID as PY2017 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different Product ID from PY2017 Plan ID.
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. (<i>auto-populated</i>)
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2018 Plan ID.
	Discontinuing product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. (<i>auto-populated</i>)
	Discontinuing product; enrollment into a different product.	Plan ID with different Product ID from PY2017 Plan ID.

Crosswalk Level	Crosswalk Reason	2018 HIOS Plan ID
Discontinue with no crosswalk	Discontinuing product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
	Continuing product; no plan available in the particular service area under than product; no enrollment option.	PY2018 HIOS Plan ID field is disabled. <i>(auto-populated)</i>
Plan Withdrawn Prior to Certification	Plan Withdrawn Prior to Certification. No enrollment option. <i>(auto-populated)</i>	PY2018 HIOS Plan ID field is disabled. <i>(auto-populated)</i>

Once the Plan ID Crosswalk template is completed, issuers must validate, finalize, and e-mail the file(s).

Template Validation	Steps
Validate Template	Click the Validate button on the 2017 Plan Crosswalk tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click the Finalize button on the 2017 Plan Crosswalk tab. The Finalize function creates the .XML file of the template.
Save Template	Save the XML Template. CMS recommends saving the validated template on the computer as a standard Excel.XLSM file and the finalized .XML file in the same folder.
Upload Template	E-mail the finalized template to CMS at QHP_Applications@cms.hhs.gov with the subject title "2017 Plan ID Crosswalk". Please note: If the XML file name is modified after finalization, CMS cannot process the Template.