Qualified Health Plan
Issuer Application Instructions

2022

[02/2021]

CMS

PY2022 QHP Instructions: Revisions

Changes made after initial document posting are listed by section.

Section	Change

Terminology Guide

Abbreviation	Term
AAAHC	Accreditation Association for Ambulatory Health Care
AV	actuarial value
AVC	Actuarial Value Calculator
BPCK	brand name pack
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COA	certificate of authority
CSR	cost-sharing reduction
DCR	data change request
DDPA	Delta Dental Plans Association
DDS	doctor of dental surgery
DMD	doctor of dental medicine
DO	doctor of osteopathy
DOS	dates of service
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECP	essential community provider
EHB	Essential Health Benefit
EOB	explanation of benefits
EPO	exclusive provider organization
FF-SHOP	Federally-facilitated Small Business Health Options Program
FFE	Federally-facilitated Exchange
FIPS	Federal Information Processing Standards
FTE	full-time equivalent
GPCK	generic pack
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HMO	health maintenance organization
HPSA	health professional shortage area
HRA	health reimbursement account
HSA	health savings account
ICD	International Classification of Disease
IP	inpatient
IRO	independent review organization

Abbreviation	Term
ISS	Interactive Survey System
LDCW	limited data correction window
MD	medical doctor
MOOP	maximum out-of-pocket
MPMG	Marketplace Plan Management Group
MSP	multi-state plan
NA	not applicable
NADP	National Association of Dental Plans
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NP	nurse practitioner
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
PA	physician's assistant
PHS	Public Health Service (Act)
PM	plan management
POS	point of service
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization
PY	plan year
QHP	qualified health plan
QIS	quality improvement strategy
RXCUI	RxNorm Concept Unique Identifiers
SADP	stand-alone dental plan
SBC	summary of benefits and coverage
SBD	semantic branded drug
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SCD	semantic clinical drug
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
SPE	State Partnership Exchange
SSM	Supplemental Submission Module
TTY	term types
URRT	Unified Rate Review Template
USP	United States Pharmacopeia

Contents

Introduction: Qualified Health Plans for 2022

As defined in the Patient Protection and Affordable Care Act (PPACA), 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 to display for consumers selecting insurance plans on HealthCare.gov.

Overview of the QHP Certification Process

You must complete and submit a QHP Application for each plan you intend to offer on the Federally-facilitated Exchange (FFE) each year. During the annual application and certification process, you ensure the plans you submit comply with the PPACA and all applicable regulations. We recommend reading all applicable published guidance, including the following items that can be found on the Center for Consumer Information and Insurance Oversight (CCIIO) website:

- A Letter to Issuers, provides guidance on offering QHPs, including stand-alone dental plans (SADPs), in the FFEs and in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). The 2022 Draft Letter to Issuers in the Federally-facilitated Exchanges displayed on December 1, 2020.

- An annual Notice of Benefit and Payment Parameters (Payment Notice) sets payment parameters and new standards to improve consumers' Exchange experience. The proposed 2022 Payment Notice displayed in the Federal Register on December 4, 2020. A final rule displayed in the Federal Register on January 19, 2021 that addressed specific proposals in the proposed 2022 Payment Notice regarding, among other things, user fees, acceptance of payments by issuers of individual market QHPs, and network adequacy standards. Where applicable, these instructions identify the policies in the proposed 2022 Payment Notice that were not addressed by the January 19, 2021 final rule as "proposed" (for example, the proposed annual limitation on cost sharing). It is your responsibility to ensure compliance with CMS regulations and guidance.

- The Market Stabilization Final Rule of 2017, the PPACA Exchange and Insurance Market Standards for 2015, and Beyond Final Rule of 2014 provide additional relevant guidance and regulations.

You can also visit the CCIIO website for general guidance on the Health Insurance Market Reforms and on the Health Insurance Marketplaces.

QHP Application Submission Process

You will submit templates, supporting documentation, and justifications for all plans you intend to have certified as part of your QHP Application. You must submit a completed QHP Application by the initial submission deadline for each plan you intend to offer, then make all necessary updates before the deadline for revising your QHP Application.

In plan year (PY) 2022, the deadline for submitting the QHP Application Rates Table Template follows the general QHP Application initial submission deadline. Submit a complete QHP Application—except for the QHP Rates Table Template—by the initial submission deadline, then submit the QHP Rates Table Template by the initial Rates Table Template deadline. You can find both deadlines in the Draft Bulletin: Proposed Timing of QHP Data Submission and Certification.

We rely on systems that automate the data collection and validation process. The systems you will use to submit your QHP Application materials depend on the Exchange model your state uses. Review our list of Submission Systems for information on which system you should use to file your QHP Applications and supporting data.

If you are applying for QHP certification in a state that does not perform plan management functions, you must submit your QHP Applications in the Health Insurance Oversight System (HIOS).

Some FFE states that do not perform plan management functions may choose to collect plan data, which may include copies of the QHP templates, in both HIOS and in the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing (SERFF). If your state collects some plan data via SERFF,

you must also submit your complete QHP Application in HIOS. These systems do not communicate, and we do not receive your plan data from SERFF.

If your state performs plan management functions, you should submit QHP Applications in SERFF in accordance with state and Centers for Medicare & Medicaid Services (CMS) review deadlines. Your state will submit all QHP Application data as specified in state guidance. No matter your state, you must submit the Unified Rate Review Template (URRT) to us via the Unified Rate Review Module in HIOS (see Rate Review Bulletin).

SADP Issuers

You may offer SADPs if you participate in the dental market as a dental-only issuer or in the medical and dental markets as a dual-product issuer. Certain sections of the QHP Application do not apply to and are not required for dental-only issuers.

You must offer the pediatric dental EHB in the individual and small group markets. QHPs are not required to offer pediatric dental EHBs on the Exchange in states where pediatric dental EHBs are covered by an SADP on the Exchange.

Use HIOS or SERFF as applicable in your state to complete the relevant application sections and templates.

SADP Voluntary Reporting Guidance

If you intend to offer Exchange-certified SADPs for PY2022 in states with FFEs, including states performing plan management functions, you are encouraged to respond to CCIIO's annual SADP Voluntary Intent to Offer Survey so we can determine if we need to ask Medical QHP issuers to include pediatric dental services in their plans designed for Exchanges that may not have SADP coverage. For PY2022, this survey will be distributed to SADP issuers in January 2021 via a HIOS email with a request to respond by February 15, 2021. SADP issuers who choose to participate can report this information via the National Association of Dental Plans (NADP) or the Delta Dental Plans Association (DDPA), which will transmit these data to CCIIO. SADP issuers may also submit data directly to CCIIO by sending the completed data survey template to dental@cms.hhs.gov. The results of the SADP Intent to Offer Survey are published annually under Published Guidance and Regulations to identify any areas within a state that lack SADP coverage.

HIOS

You must register in HIOS to obtain a HIOS Issuer ID and record issuer administrative contact information. Refer to the HIOS Quick Reference Guide and the HIOS Portal User Manual for more information on registering and navigating through the portal.

The relevant HIOS modules are as follows:

- **Plan Finder Product Data Collection Module:** This is where you submit, review, and modify administrative data. Refer to the HIOS Plan Finder—Issuer User Manual for detailed instructions.

- **QHP Issuer Module:** This is where you submit, review, and modify QHP Application data on attestations, licensure and good standing, accreditation, essential community providers (ECPs), and network adequacy to offer plans on the FFE. You will use tabs to access the sections where you will submit templates and documentation. Refer to the Issuer Module User Guide for detailed instructions.

- **QHP Benefits and Service Area Module:** This is where you submit, review, and modify QHP Application data pertaining to Plans and Benefits, Service Areas, Formularies, and Transparency in Coverage to offer plans on the FFE using an online interface and Microsoft Excel templates. Refer to the Benefits & Service Area Module User Guide for detailed instructions.

- **QHP Rating Module:** This is where you submit, review, and modify QHP Application data pertaining to plan rates and business rules to offer plans on the FFE. Refer to the Rating Module User Guide for detailed instructions.

- **Unified Rate Review System Module:** This is where you submit the URRT. Refer to the Unified Rate Review System Module User Guide for detailed instructions.

- **QHP Plan Preview Module:** This is where you view plan data and issuer data as it will display in Plan Compare on HealthCare.gov if you plan to offer QHPs or on-Exchange SADPs. Refer to the Plan Preview User Guide for more information.
- **Supplemental Submission Module (SSM):** This is where you submit URL data for the Plan Compare tool consumers can access on HealthCare.gov. Refer to the Supplemental Submission Module User Guide for detailed instructions.

SERFF

If your state performs plan management functions or operates a State-based Exchange on the Federal Platform (SBE-FP), submit your QHP Application via SERFF. Contact your 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, contact the relevant state.

Plan Management (PM) Community

Use the PM Community to complete QHP certification activities and review our communication with you regarding your QHP Applications. If we require Plan ID Crosswalk Templates and supporting documentation from your issuer, submit them in the Plan ID Crosswalk tab of the PM Community. Refer to the PM Community page of the QHP certification website for more information on using this system.

QHP Application Sections, Associated Templates, and Supporting Documentation

The QHP Application requires you to submit Excel templates that contain issuer and plan data. Table 1 lists all materials required for the HIOS submission process according to where they appear in the QHP Application.

Note: Not all QHP Application sections require the submission of supporting documentation or justifications. Appendix C 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 1. Necessary Materials

HIOS Module	Application Area	Required Materials
Plan Finder Module	Administrative	*Marketplace General Information* fields in the HIOS Plan Finder Module*
Issuer Module	Program Attestations	◆ FFE issuers respond to attestations in the HIOS Issuer Module* ◆ If your state performs plan management functions, submit the State Partnership Exchange Issuer Program Attestation Response Form in SERFF ◆ State Partnership Exchange (SPE) Issuer Program Attestation Response Form (SBE-FP issuers should follow state guidance) ◆ Compliance Plan ◆ QHP Compliance Plan and Organizational Chart Cover Sheet ◆ Organizational Chart ◆ Program Attestation Justification for the Federally-facilitated Exchange (Optional) ◆ Interoperability Attestation and Justification Form (not required for SADP, FF-SHOP, and SBE-FP issuers)
Issuer Module	State Licensure (optional)	◆ Respond to attestations and upload state licensure documentation ◆ Licensure Documentation*

HIOS Module	Application Area	Required Materials
Issuer Module	Good Standing (optional)	◆ Respond to attestations and, if necessary, upload documentation ◆ Good Standing Supplemental Response* ◆ Corrective Action Plan
Issuer Module	Accreditation	◆ Respond to terms and conditions ◆ Upload the Quality Improvement Strategy (QIS) ◆ Accreditation Certificate ◆ QIS
Issuer Module	Essential Community Providers (ECPs)/ Network Adequacy	◆ ECP/Network Adequacy Template* ◆ All issuers must submit ECP data ◆ Only issuers in network breadth pilot states need to submit network adequacy data ◆ Supplementary Response: Inclusion of Essential Community Providers ◆ Network Adequacy Access Plan and Cover Sheet (if asked to submit)
Benefits and Service Area Module	Network ID	◆ Network ID*
Benefits and Service Area Module	Service Area	◆ Service Area Template* ◆ Service Area Partial County Supplemental Response
Benefits and Service Area Module	Prescription Drugs	◆ Prescription Drug Template ◆ Combined Prescription Drug Supporting Documentation and Justification ◆ Discrimination—Treatment Protocol Supporting Documentation and Justification

Benefits and Service Area Module	Plans & Benefits	◆ Plans & Benefits Template*
		  Plans & Benefits Add-In
		  Plans & Benefits Add-In Change Log
		◆ Discrimination—Language: Supporting Documentation and Justification
		◆ Discrimination—Cost-Sharing Outlier: Supporting Documentation and Justification
		◆ EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification
		◆ Stand-Alone Dental Plan Actuarial Value Supporting Documentation*
		◆ Stand-Alone Dental Plan—Description of EHB Allocation Supporting Documentation and Justification*
		◆ Silver/Gold: Supporting Documentation and Justification
		◆ Unique Plan Design—Supporting Documentation and Justification

Benefits and Service Area Module	Transparency in Coverage	Transparency in Coverage Template
Rating Module	Rates Table	Rates Table Template*
Rating Module	Business Rules	Business Rules Template*
Supplemental Submission Module	URL Collection	Submit URLs for plan information*
Unified Rate Review Module	Unified Rate Review	Unified Rate Review Template

* Applicable to SADP issuers.

Review Periods, Revision Process, and Certification

QHP certification involves data submission, data review, and data revision (as necessary). We provide several opportunities for data submission. You must submit your materials by each QHP Application submission deadline so that we can review them for compliance with market-wide standards and other regulations.

We notify you of any necessary corrections we identify during review. If you are applying to offer plans on-Exchange, these review results list critical data errors, including the section in the application where each error has been found, and describe how to correct the errors.

Between the initial submission deadline and the final submission deadline, you may make necessary changes to your QHP Applications, including any changes mandated in our review, and upload revised QHP data templates. After the close of the final submission deadline, issuers in FFE and SPE states must submit a Data Change Request (DCR) to perform data changes to QHP data templates. DCRs are not required for issuers to submit corrections we identify.

If you need to correct a data error after the final submission window, you should submit a DCR as soon as possible. We will review all submitted DCRs on a rolling basis and notify you if we approve your requested changes. If you are approved to make changes, you will be notified when you may enter a submission window to correct the data errors before Open Enrollment. All data submitted may be subject to compliance action, including issuer- and state-requested changes. All data errors and corrections must be addressed before the affected QHPs may be certified or displayed on HealthCare.gov.

We will again offer an "Early Bird" review round. If you submit complete QHP Applications before the Early Bird submission deadline, we will review your applications and return them in time for you to correct errors and resubmit before the initial submission deadline.

We certify plans based on the information contained in the application. You must notify us if you alter a QHP Application. We reserve the right to revisit the certification of any plan. We also reserve the right to decertify a plan during the plan year if we determine information in the relevant QHP Application is inaccurate, incomplete, or does not meet certification standards or program requirements.

We will routinely monitor ongoing compliance with certification standards and other program requirements. These standards and requirements remain in place throughout the entire plan year.

We certify each plan's compliance with QHP standards based on our review of the application and any information we receive from the applicable state regulator, including appropriate state approvals. Regardless of our determinations, you must comply with all applicable state and federal requirements.

Service Area DCR Process

You may not change any plan's service area after the initial submission deadline unless you submit and we approve a DCR, even if the change is a response to a correction we or a state have dictated. Changes in service area are not always caused by changes to the Service Area Template. For instance, changing the service area ID associated with a plan from S001 to S002 in the Plans & Benefits Template constitutes a change to service area.

You must submit service area data change requests by the deadline listed in the Draft Bulletin: Proposed Timing of QHP Data Submission and Certification to allow us sufficient time for review. Only submit changes to your QHP Applications after we approve the DCRs and before the deadline for changing QHP Applications.

Retrieve required forms and instructions from the QHP certification website.

New for PY2022

If you are applying to issue Medical QHPs, you must submit an Interoperability Attestation and Justification Form indicating that you meet the requirements of the CMS Interoperability & Patient Access Final Rule that was published on May 1, 2020 and established at 45 Code of Federal Regulations 156.221. If you are unable to attest that you will meet all requirements by July 1, 2021, you must complete the justification in the form to describe the following:

- Detailed reasons for non-compliance
- The effects non-compliance will have on enrollees
- Your current/proposed means of providing health information to enrollees
- A proposed interim mitigation strategy to address your current implementation challenges.

Machine-readable review results will be made available in the PM Community to communicate errors contained within your machine-readable data, such as:

- Data missing the next coverage year
- Data in the wrong format
- Data with text formatting issues.

Review Tools

We provide review tools you can use to check for QHP Application errors that would cause correction notices. Run each of the following tools that is applicable to your issuer type (SADP or QHP), to identify and correct data errors before uploading materials to HIOS or SERFF. Our review cycle is limited, and your plans may not be reviewed on time if you do not use these tools to prevent errors. Appendix D provides a high-level description of each tool's functionality.

Using this Document

This document uses screenshots and written guidance to explain each step required to complete the PY2022 QHP Application. Hyperlinks throughout the document will direct you to external content that you may need to use to complete your application.

Bolded text indicates items and information that you will use, enter, or select from a drop-down menu, such as the option **Yes** to indicate that you agree to an attestation.

Italicized text indicates the names of fields into which you will enter information, such as your *HIOS Issuer ID*. *Italicized text* may also be used to indicate document titles, such as the *HHS Notice of Benefit and Payment Parameters for 2018*.

Underlined text is used for emphasis, such as to specify that you should not complete a certain step.

Hyperlinks are indicated with blue font and are underlined. Clicking a hyperlink will direct you to a location outside of this document to reference additional information.

The remainder of this document will serve as step-by-step instructions for completing the PY2022 QHP Application, navigating through each of the modules, and identifying specific policy and submission criteria for each section.

1. Issuer Module

Users of the Issuer Module are assigned to one or both of the following roles: the Issuer Submitter (an individual who submits the data necessary to complete the Issuer Module) and the Issuer Validator (an individual who verifies that all sections of the Issuer Module are accurate). Both roles can cross-validate data elements to ensure consistency throughout the application, but only the Issuer Validator can submit the application after cross-validation ends.

This module is organized by its application sections and consists of the Summary, Data Submitter, Data Validator, and Final Submission pages.

The Summary page is the first page visible when navigating to the Issuer Module. You will use it to start a new application, resume a pending application, or view a submitted application for the HIOS Issuer IDs to which you have access.

The Data Submitter page consists of tabs you can use to navigate the sections within the Issuer Module: Program Attestations, State Licensure, Good Standing, Accreditation, and Essential Community Providers (ECP)/Network Adequacy. Within each tab, you will answer questions and upload supporting documentation related to the Qualified Health Plan (QHP) Application as well as a completed ECP/Network Adequacy Template for system validation.

The Data Validator page consists of the same tabs as the Data Submitter page, but provides options to view the data read-only and to download the supporting documentation to validate its accuracy. This section allows Issuer Validators to upload supporting documentation and answer supplemental responses via the Health Insurance Oversight System (HIOS).

The Final Submission page allows the Issuer Submitter or Issuer Validator to cross-validate data between modules, and allows the Issuer Validator to submit the QHP Application.

Each tab guides you through the process of creating a new application or editing an existing application. The Data Submitter page directs to the Program Attestations, Accreditation, and ECP/Network Adequacy sections (see Figure 1-1). The Licensure and Good Standing sections are optional; Issuer Submitters are not required to submit these sections to complete the module.

Figure 1-1. 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 lists all sections of the application, the last modified date, and the name of the user who last modified the section (see Figure 1-2). The Data Validator page lists the same information.

Figure 1-2. Review Page Snapshot

Data Submitter	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
Program Attestations	01/25/2017 10:36:37 PM	FUNC02	Submission Completed
State Licensure	01/25/2017 10:36:42 PM	FUNC02	Submission Completed
Good Standing	01/25/2017 10:36:47 PM	FUNC02	Submission Completed
Accreditation	01/25/2017 10:36:52 PM	FUNC02	Submission Completed
ECP/Network Adequacy	01/25/2017 10:36:58 PM	FUNC02	Submission Completed

Section 1A: Program Attestations

1. Introduction

In the Program Attestations section, you attest to your intent to comply with Federally-facilitated Exchange (FFE) requirements if you are an FFE issuer filing via HIOS (Figure 1A-1). It includes the following four subsections of attestations (in order):

- Attestations required of both Medical QHP and stand-alone dental plan (SADP) issuers

- Attestations required of Medical QHP issuers only

    This subsection includes the Interoperability Attestation and Justification Form required of individual Medical QHP issuers in the FFE only. This form is not required for Federally-facilitated Small Business Health Options Program (FF-SHOP), State-based Exchange on the Federal Platform (SBE-FP), or SADP issuers.

- Attestations required of SADP issuers only

- Optional attestations.

You must respond to all four subsections. Respond "Not Applicable" to any subsections that do not apply to you.

If your state performs plan management functions, complete and submit the 2022 State Partnership Exchange Issuer Program Attestation Response Form and the Interoperability Attestation and Justification Form via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing (SERFF).

Figure 1A-1. Program Attestations Application Section

2. Data Requirements

Compile the following information to complete this section:

1. Company organizational chart: Save the organizational chart using the naming convention in Table C-1.

2. Company compliance plan

3. [Compliance Plan and Organizational Chart Cover Sheet](): To merge the Compliance Plan and Organization Chart Cover Sheet PDF with an existing compliance plan PDF file, use the Combine Files or Insert Pages functions in Adobe Acrobat. Save the compliance plan using the naming convention in Table C-1.

4. [Justification Form](): Only required if you select **No** for the optional compliance plan attestation. Save the justification form using the naming convention in Table C-1.

5. [State Partnership Exchange Issuer Program Attestation Response Form](): Only required if your state performs plan management functions and you are submitting in SERFF. Save the form using the naming convention in Table C-1.

6. [Interoperability Attestation and Justification Form](): Only required for individual Medical QHPs in the FFE. This form is not required for FF-SHOP, SBE-FP, or SADP issuers.

3. Quick Reference

Key Changes for 2022
If you are applying to issue Medical QHPs, you must submit an [Interoperability Attestation and Justification Form]() indicating that you meet the requirements of the Centers for Medicare & Medicaid Services (CMS) Interoperability & Patient Access Final Rule. If you cannot meet the requirements, you are required to include a narrative justification in the form. This requirement does not apply for SADP-only, FF-SHOP, or SBE-FP issuers.

Tips for the Program Attestations Section

- You must respond to all attestation subsections.
- If you only issue Medical QHPs, respond **Not Applicable** to the Attestations required in the SADP-only issuers subsection.
- If you only issue SADPs, respond **Not Applicable** to the Attestations required in the Medical QHP-only issuers subsection.
- We strongly encourage you to respond **Yes** to the optional compliance plan attestation and upload a compliance plan that includes the Compliance Plan and Organizational Chart Cover Sheet. If you respond **No** to the optional compliance plan attestation, you must upload a justification form.
- You must upload supporting documents for your responses to the attestations.
- Use the justification form only if you are submitting plans to the FFE using HIOS.
- Use the State Partnership Exchange Issuer Program Attestation Response Form only if your state performs plan management functions.
- If you issue Medical QHPs in the FFE or in a state that performs plan management functions, you must complete the Interoperability Attestation and Justification Form. If you do not attest to meeting all requirements by July 1, 2021, you must provide a narrative justification. If you did not offer plans on the Exchange in PY2021, you have until January 1, 2022, to implement these requirements.

Additional Resources

- There are [supporting documents]() for this section.
- There are no instructional videos for this section.
- There are no templates for this section.

4. Detailed Section Instructions

To participate in the FFE, you must respond to all Program Attestations subsections and upload supporting documentation or justifications.

Attestation Area	Steps
Attestations required of both Medical QHP and SADP issuers	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if you agree to the listed attestation. If you select **Yes**, you must submit an Organizational Chart. Use the document upload feature in this subsection and select "Organizational Chart" as the document type.

Attestation Area	Steps
	◆ **No**—if you do not agree to the listed attestation. If you select **No**, you must still submit an Organizational Chart or "Other" document. Note: To offer certified QHPs or SADPs you must respond **Yes**.
Attestations required of Medical QHP issuers only	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if you agree to the listed attestation. ◆ **No**—if you do not agree to the listed attestation. ◆ **Not Applicable**—if you are not submitting for Medical QHP certification. Note: If you are applying to offer Medical QHPs, you must respond **Yes** with regard to those Medical QHPs. If you are not applying to offer Medical QHPs, select **Not Applicable**. Complete and upload the Interoperability Attestation and Justification Form. This form is not required for FF-SHOP, SBE-FP, or SADP issuers. Complete the four attestations with the following choices: ◆ **July 1, 2021**—if you will be in compliance with the stated requirement by this date. ◆ **November 1, 2021**—if you will be in compliance with the stated requirement by this date. ◆ **January 1, 2022**—if you will be in compliance with the stated requirement by this date. ◆ **Other**—if you will be in compliance with the stated requirement at a date later than January 1, 2022 (this requires a write-in response). If you do not select **July 1, 2021**, for every question, you must complete the Justification at the end of the document, which consists of pre-populated responses (select all that apply) and a narrative response (required if completing the justification section). If you did not offer plans on the Exchange in PY21, you are not required to implement these requirements until **January 1, 2022**, and may indicate this on the form.
Attestations required of SADP issuers only	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if you agree to the listed attestation. ◆ **No**—if you do not agree to the listed attestation. ◆ **Not Applicable**—if you are not submitting for SADP certification. Note: If you are applying to offer SADPs, you must respond **Yes** with regard to those SADPs. If you are not applying to offer SADPs, select **Not Applicable**.
Optional Attestations	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if you agree to the listed compliance plan attestation. If you select **Yes**, submit the Compliance Plan and the Compliance Plan and Organizational Chart Cover Sheet. Use the document upload feature in this subsection and select **Compliance Plan** as the document type. ◆ **No**—if you do not agree to the listed compliance plan attestation. If you select **No**, complete and submit the justification form. Use the document upload feature in this subsection and select **Other** as the document type. You may still submit a Compliance Plan if you select **No**. Note: We strongly encourage you to respond **Yes** and upload a Compliance Plan and the Compliance Plan Cover Sheet.

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

Attestation Area	Attestation
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 Code of Federal Regulations (CFR) Parts 153, 155, and 156.
Attestations required of Medical QHP issuers only	Applicant agrees to adhere to all applicable requirements in 45 CFR Parts 146, 147, 155, and 156, including those related to the segregation of funds for abortion services. Applicant attests to compliance with requirements finalized in Interoperability and Patient Access Final Rule by uploading the Interoperability Attestation and Justification Form. This form is not required for SADP, FF-SHOP, or SBE-FP issuers.

Attestation Area	Attestation
Attestations required 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 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 the Department of Health and Human Services (HHS) for review. Applicant will upload a copy of the applicant's compliance plan.

If you respond **No** to the optional attestation, you must provide a justification for why you are not providing a compliance plan. See Figure 1A-2 for a sample justification form.

Figure 1A-2. Sample Justification Form

Optional Program Attestation Justification for the Federally-facilitated Exchange

Complete this form if you are a Federally-facilitated Exchange (FFE) issuer who is submitting your Qualified Health Plan (QHP) Application in the Health Insurance Oversight System (HIOS). If you apply via the System for Electronic Rate and Form Filing (SERFF), submit a justification on the State Partnership Exchange Issuer Program Attestations Response form.

The compliance plan attestation is optional, but we encourage all issuers to respond **Yes** and upload a Compliance Plan and the Compliance Plan Cover Sheet in the Issuer Module.

If you respond **No** to the optional Compliance Plan Program attestation, provide an explanation below.

Issuer Name: _____

HIOS ID: _____

CMS   1 of 1   2022 QHP Application Instructions

As you complete the Compliance Plan and Organizational Chart Cover Sheet, respond **Yes** or **No** to each evaluation criterion and identify the page number in the compliance plan where language supporting the evaluation criterion is found. Provide any requested organizational chart information on the same cover sheet.

We expect you to acknowledge that your compliance plans apply to Exchange products and operations and to provide examples of specific plans or processes that comply with Exchange requirements (see the Compliance Plan Contents section of the Compliance Plan and Organizational Chart Cover Sheet). For example, you might use an Exchange module as a part of employees' compliance training or develop audit plans to evaluate Exchange compliance risks.

See Figure 1A-3 for a sample partially completed Compliance Plan and Organizational Chart Cover Sheet.

Figure 1A-3. Sample Compliance Plan and Organizational Chart Review Cover Sheet

QHP Issuer Compliance Plan and Organizational Chart

Review Cover Sheet

Submit a Compliance Plan and Organizational Chart as part of your QHP Application. We review Compliance Plans based on criteria listed below. Respond to the evaluation criteria and, where applicable, state the page number where language supporting the response can be found. We will use this initial evaluation and review cover sheet to evaluate the adequacy of the Compliance Plan and Organizational Chart and to help us monitor ongoing compliance.

We reserve the right to identify weaknesses in your Compliance Plan or the Organizational Chart and to require you to address those weaknesses at a later date.

Evaluation Criteria	Yes	No	Page Number
Compliance Plan and Organizational Chart Submissions			
Applicant included a completed PY2022 cover sheet in the QHP application.	○	○	N/A
Applicant uploaded a copy of its Compliance Plan.	○	○	N/A
Applicant uploaded a copy of the Organizational Chart.	○	○	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?	○	○	
2. Does the Compliance Plan include written standards of conduct for employees?	○	○	
3. Does the Compliance Plan provide guidance for employees, contractors, subcontractors, or other applicable entities on the process for dealing with potential compliance issues?	○	○	
4. Does the Compliance Plan describe the methods, process, and procedures used to implement the Compliance Program?	○	○	

CMS   1 of 3   2022 QHP Application Instructions

Attestations 1-4 in the Interoperability Attestation and Justification Form each summarize a separate requirement of the Interoperability and Patient Access Final Rule, detailed in 45 CFR 156.221. As you complete this form, respond to each attestation with the earliest listed date by which you will have completed the stated requirement. The expected implementation date for each requirement is July 1, 2020. If you will not comply by July 1, 2020, and enter a different response, you must provide a justification at the end of the Interoperability Attestation and Justification Form. You should select all suggested responses that apply and provide a narrative response. If you did not offer QHPs on the Exchange in PY2021, you have an extended deadline of January 1, 2022. See Figure 1A-4 for a sample justification form.

Additional details for each attestation are listed below:

Attestation 1: A secure API and its necessary features are detailed in full in 45 CFR 156.221. You may also read our Best Practices for Payers and App Developers document online, which includes implementation and testing guidance for payers.

Attestation 2: The information detailed in full in 45 CFR 156.221 includes the following:

    a) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are being appealed, and provider remittances and enrollee cost-sharing pertaining to such claims, no later than one business day after a claim is processed

    b) Encounter data from capitated providers, no later than one business day after data concerning the encounter is received by the QHP issuer

    c) Clinical data, including laboratory results, if the QHP issuer maintains any such data, no later than one business day after data is received by the issuer.

Attestation 3: The information to be included on the issuer's website is detailed in full in 45 CFR 156.221 and includes the following:

    a) API syntax, function names, required/optional parameters and their data types, return variables and their types/structures, and exception and exception handling methods and their returns

    b) Software components and configurations an application must use to interact with the API and process its response(s)

    c) Technical requirements for an application to be registered with any authorization server(s) deployed along with the API.

Attestation 4: The information to be included on the issuer's website for enrollees is detailed in full in 45 CFR 156.221 and includes the following:

    a) General information on steps the individual may consider taking to help protect the privacy and security of enrollee health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information

    b) An overview of which types of organizations or individuals are and are not likely to be HIPAA-covered entities, the oversight responsibilities of the Office for Civil Rights and the Federal Trade Commission, and how to submit a complaint to the HHS Office for Civil Rights and the Federal Trade Commission. as described in 45 CFR 156.221.

You may find the following best practices resource on Patient Privacy and Security Resources – Supporting Payers Educating their Patients helpful.

Figure 1A-4. Sample Interoperability Attestation and Justification Form

Interoperability Attestation and Justification Form: Compliance with Health Data and Plan Information Interoperability Requirements

Issuer Name: _____

HIOS ID: _____

Instructions: This program attestation will evaluate your compliance with the requirements finalized in the Interoperability and Patient Access Final Rule published on May 1, 2020. By July 1, 2021, you must implement the requirements detailed in 45 Code of Federal Regulations (CFR) 156.221, which require the implementation and maintenance of a patient access application programming interface (API) and related documentation. If you did not offer a plan on the Marketplace in plan year (PY) 2021, you have an extended implementation deadline of January 1, 2022, for each requirement listed below. Please refer to PY2022 Issuer Instructions for further detail.

If you issue plans on the Federally-facilitated Exchange, submit this form as part of your Qualified Health Plan Application in the Health Insurance Oversight System (HIOS). If you issue plans on a State Partnership Exchange, submit your application, including this form, via the System for Electronic Rate and Form Filing. This form is not required for stand-alone dental plans, Federally-facilitated Small Business Health Options Programs, and State-based Exchanges on the Federal platform. You must respond to the questions below to attest to your compliance with each requirement. If you respond anything other than "July 1, 2021" for each attestation, you must submit a narrative justification at the end of the form.

Attestation 1: The issuer must fully implement a secure API that both:

   a) Allows all enrollees to access their claims and encounter information through a third-party application of the enrollee's choice and

After entering all data, click **Save** to ensure no data are lost. The next section of the Instructions for the plan year (PY) 2022 QHP Application is State Licensure.

Section 1B: State Licensure (Optional)

1. Introduction

In the State Licensure section, you document your licensure status and demonstrate that you satisfy licensure requirements for applicable QHP markets, service areas, and products (Figure 1B-1). To verify licensure, upload a copy of your state license, certificate of authority (COA), certificate of compliance, or equivalent document/form for each state in which you seek QHP certification. You may apply for certification by the initial submission deadline without documentation, but must then submit evidence of licensure during the window for changing QHP Applications.

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

Figure 1B-1. State Licensure Application Section

2. Data Requirements

Upload one of the following:

1. State license
2. COA
3. Certificate of compliance
4. A document equivalent to one of the above.

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the State Licensure Section
◆ The second licensure question only displays if the user selected **No** as the answer for Question 1.
◆ Supporting document upload is only requested if the user selected **Yes** as the answer for either Question 1 or Question 2.
◆ Provide licensure documentation for all products and service areas in which you intend to offer a QHP. This applies to all licensed issuers, including any affiliated or other issuers underwriting the dental benefits that the QHP proposes to offer.
◆ Submit <u>one</u> form of licensure documentation (state license, COA, certificate of compliance, or equivalent).
◆ If you are not yet licensed and therefore are unable to provide licensure documentation during the initial application submission, submit evidence of licensure during the QHP Application resubmission window.

- There are optional supporting documents for this section.
- There are no instructional videos for this section.
- There are no templates for this section.

4. Detailed Section Instructions

If you choose to submit information for this section, you will use radio buttons that have conditional functionality (Figure 1B-2). This means that the number of questions that you answer will depend on the response you select. The second licensure question only displays if you select **No** for *Licensure Question 1*. If you respond **Yes** to *Licensure Question 2*, upload supporting documents. If you respond **No**, enter a date.

Licensure Question 1	Steps
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?	Choose from the following: ◆ **Yes**—if you are licensed for every product type and every service area for which you are applying. If you select **Yes**, upload supporting documentation. ◆ **No**—if you are <u>not</u> licensed for every product type and every service area for which you are applying. If you select **No**, proceed to the next step.

Licensure Question 2	Steps
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?	Choose from the following: ◆ **Yes**—if you are licensed for some but not all product types or service areas for which you are applying. If you select **Yes**, upload supporting documentation. ◆ **No**—if you are <u>not</u> licensed for any of the product types or service areas for which you are applying. If you select **No**, enter the estimated date of licensure.

Figure 1B-2. Question 1 and Question 2 Based on Response

After entering all data, click **Save** to ensure no data are lost. The next section of the Instructions for the PY2022 QHP Application is Good Standing.

Section 1C: Good Standing (Optional)

1. Introduction

In the Good Standing section, you demonstrate compliance with all applicable state solvency and regulatory requirements (Figure 1C-1). You must be licensed in the state in which you are applying to satisfy the good standing standard.

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

If you do not comply with the good standing standard, provide the following information:

1. If applicable, a description of how you will comply with state solvency requirements

2. If applicable, a description of how you will respond to corrective actions.

Figure 1C-1. Good Standing Application Section

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the Good Standing Section
◆ If the user responds **No** to Question 1, no additional information is needed to proceed. ◆ If the user responds **Yes** to Question 2, the user may upload supporting documents and provide a justification. ◆ If the user responds **No** to Question 2, no additional information is needed to proceed. ◆ If you do not comply with the state solvency requirements or are under corrective action related to financial review, complete supporting documentation and provide a justification.

Additional Resources
◆ There are optional supporting documents for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

If you choose to submit information for this section, you will use radio buttons that have conditional functionality. This means that the information requested will depend on the response that you select.

If you respond **Yes** to Question 1, you may upload supporting documentation and provide a justification. If you respond **No** to Question 1, no additional information is needed to proceed.

Good Standing Question 1	Steps
Is the applicant seeking QHP certification for this state currently out of compliance with any applicable state solvency requirements for the calendar year in which it is applying to offer QHPs?	Choose from the following: ◆ **Yes**—if you do <u>not</u> comply with state solvency requirements. If you select **Yes**, upload supporting documentation and a justification in this section and select **Solvency Compliance** as the document type. ◆ **No**—if you <u>comply</u> with state solvency requirements. If you select **No**, proceed to the next step.

If you respond **Yes** to Question 2, you may upload supporting documents and provide a justification.

Good Standing Question 2	Steps
Is the applicant currently under any corrective action related to financial review?	Choose from the following: ◆ **Yes**—if you <u>are</u> under corrective action related to financial review. If you select **Yes**, upload supporting documentation in this section and select **Corrective Action** as the document type. ◆ **No**—if you are <u>not</u> under corrective action related to financial review. If you select **No**, proceed to the next section of the application.

If you do not comply with the good standing standard, you must submit supporting documentation and a justification.

Good Standing Supporting Documentation
If you respond **Yes** to question 1 (you do <u>not</u> comply with state solvency standards), upload a description of how you intend 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 　▪ Timeframe for complying. The justification should explain the conditions that caused financial insolvency (such as insufficient premium income or catastrophic medical expenses).
If you respond **Yes** to question 2 (you <u>are</u> under corrective action), upload a description of how you intend 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 　▪ Timeframe for implementing the corrective action plan. The justification should explain how a corrective action plan or equivalent document will address the issues identified by the state.

After entering all data, click **Save** to ensure no data are lost. The next section of the Instructions for the PY2022 QHP Application is Accreditation.

Section 1D: Accreditation

1. Introduction

In the Accreditation section, you enter information to satisfy the accreditation QHP certification requirement (Figure 1D-1). You can provide information for an accredited product in the Commercial, Medicaid, or Exchange markets. These instructions apply only if you are filing via HIOS to issue a QHP on the FFE.

If your state performs plan management functions or has a State-based Exchange on the Federal Platform, comply with the requirements for accreditation data collection specified by your state.

2. Data Requirements

To complete this section, compile information about which accrediting entity you are accredited by—the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC).

Figure 1D-1. Accreditation Application Section

3. Quick Reference

Key Changes for 2022
◆ We anticipate resuming activities related to the collection and reporting of quality improvement information for the Quality Improvement Strategy (QIS) during the PY2022 QHP certification period.

Tips for the Accreditation Section
◆ Only provide information on accredited products in the same state and for the same legal entity that submits the QHP Application.
◆ Provide accrediting entities with your legal issuer name and the HIOS Issuer ID used in your QHP Application to ensure the HIOS Issuer ID is included in the data file the accrediting entity provides to us.

Additional Resources
◆ There are optional supporting documents for this section.
◆ There are no instructional videos for this section.
◆ There are no templates for this section.

4. Detailed Section Instructions

If the answer to the accreditation question is **Yes**, an additional section will appear for you to select an accrediting entity from the list. Selecting an option from the list will display the associated templates.

Accreditation Question	Steps
Does the applicant currently have any Commercial, Medicaid, or Exchange health plans in this state, [state of issuer identified], accredited by an HHS-recognized accrediting entity?	Choose from the following: ◆ **Yes**—if you have existing health plan accreditations on any products in the Exchange, Commercial, or Medicaid market from NCQA or URAC. If you are dual-product issuer with an accredited medical plan, you should also select **Yes**. Proceed to the next step. ◆ **No**—if you are accredited by AAAHC, are only offering SADPs, or are not currently accredited by NCQA or URAC.

Accreditation Responses	Steps
If you respond **Yes** to the above question, you must then select the accrediting entity.	Choose from the following: ◆ **NCQA**—if you are accredited by NCQA. ◆ **URAC**—if you are accredited by URAC. ◆ **NCQA & URAC**—if you are accredited by both NCQA and URAC.
If you respond **No** to the question because you are accredited by AAAHC, you must email in the required documents.	If you are accredited by AAAHC you should email required documentation to CMS_FEPS@cms.hhs.gov.

After responding to the above question, complete the Terms and Conditions attestation, regardless of your response (Figure 1D-2).

Figure 1D-2. Displays the Terms and Conditions Acceptance for All Issuers

You may upload copies of your accreditation certificates into HIOS.

Accreditation Certificate	Steps
Scan Certificate	Scan each accreditation certificate (one per accredited market type). If you are accredited by NCQA and do not have a copy of your accreditation certificate, use the NCQA Interactive Survey System (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	Save the accreditation certificate using the naming convention in Table C-1. For example: "12345_NCQA.pdf."
Upload Certificate	Upload the saved files in the Accreditation section of the HIOS Issuer Module. Refer to the Issuer Module User Guide for further instruction.

If you are entering the <u>initial</u> year of QHP certification you must schedule (or plan to schedule) a review of your QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). You do not need to be accredited in your initial year of QHP certification, but you must be accredited 90 days before the first day of Open Enrollment in your second year. We review issuers that crosswalk enrollees to a new HIOS Issuer ID for accreditation based on their cumulative years of certification. Therefore, you must ensure that the receiving HIOS Issuer ID issuer is appropriately accredited.

If you are a <u>second</u>-year issuer that immediately pursued Exchange certification after your initial year of certification and have an accreditation status of "scheduled" or "in process," upload documentation from your accrediting entity indicating that you have completed the policies and procedures review and are scheduled for or are in the process of completing additional review.

If you were previously certified, but did not pursue certification in the prior years and are pursuing certification in the current year, you will be held to the second-year accreditation standard (i.e., you must be accredited 90 days before the first day of Open Enrollment).

If you are entering your <u>fourth</u> consecutive year of QHP participation, you must be accredited in the Exchange market with one of the following statuses:

- AAAHC—Accredited
- NCQA—Excellent, Commendable, Accredited, or Provisional
- URAC—Full or Conditional.

You will be considered a fourth-year issuer after you have participated on the Exchange market for four consecutive years, including the years of participation for any crosswalked HIOS Issuer IDs.

After entering all data, click **Save** to ensure no data are lost. The next section of the Instructions for the PY2022 QHP Application is ECP/Network Adequacy.

Section 1E: Essential Community Providers/Network Adequacy

1. Introduction

In the Essential Community Providers (ECP)/Network Adequacy section, you demonstrate that you have a sufficient number and geographic distribution of ECPs and submit provider data in each network associated with a QHP (Figure 1E-1).

2. Data Requirements

To complete this section, compile the following:

1. HIOS Issuer ID

2. Issuer state

3. Completed Network ID Template

4. If completing the network adequacy portion 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 the provider name, National Provider Identifier (NPI), specialty and facility type, street address of the location providing services, city, state, county, and ZIP Code
Note: You only need to populate the network adequacy sections of the template if we notify you by email that you must provide them.

5. A list of ECPs in each of the proposed networks, including the provider name, NPI, ECP category, street address of the 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)

9. Network Adequacy Access Plan with Cover Sheet (only if you are notified by email that you must submit access plans).

3. Quick Reference

Key Changes for 2022

◆ You will select a "dummy" provider record (ECP reference number ZZ-000001) embedded within the Select ECPs tab of your ECP/Network Adequacy Template to define a network without providers, rather than manually entering a "dummy" record as instructed in previous years. This "dummy" provider record appears as the last provider within the Select ECPs tab of the ECP/Network Adequacy Template. Only select this "dummy" provider record if you meet one of the following criteria:

- You operate in a service area in which there are no available ECPs on the Final PY2022 HHS ECP List.

- You operate an integrated health care delivery system that provides professional health care services exclusively through physicians you employ directly or through a single contracted medical group that does not include any providers on the Final PY2022 HHS ECP List. In this case, you must instead include a list of your providers on the ECP Write-in Worksheet that must be submitted along with the ECP/Network Adequacy Template.

- You rely exclusively on the Final PY2022 List of Available ECP Write-ins or have not yet recruited ECPs to participate in your network and are unable to include any providers on the Final PY2022 HHS ECP List.

Tips for the ECP/Network Adequacy Section

General
◆ Complete the Issuer Information section on the User Control tab before creating and entering data into the other tabs.

<table>
<tr><td colspan="2" style="text-align:center">Tips for the ECP/Network Adequacy Section</td></tr>
</table>

- <u>Do not</u> change the file names on ECP/Network Adequacy files after finalizing the template. This file-naming convention helps us identify your ECP/Network Adequacy Template. If you change the file name, we may issue a correction.
- Complete the Network ID Template before completing the ECP/Network Adequacy Template.

ECP
- Provide hospital bed-count information as part of the ECP portion of your ECP/Network Adequacy Template.
- You will be evaluated against a 20 percent ECP standard.
- If you score below the 20 percent ECP standard using the ECP tool to calculate your score, you should continue making efforts to recruit additional providers to your networks while concurrently completing the ECP Supplemental Response Form to describe those ongoing recruitment efforts.
- The Available ECP Write-in List for the PY2022 QHP certification process will be made available within the rolling Draft PY2023 ECP List.

Network Adequacy
- Unless you have been notified by email that you are issuing a Medical QHP in a network breadth pilot state, you are <u>not</u> required to submit network adequacy data (Individual Providers or Facilities & Pharmacies) via the ECP/Network Adequacy Template.
- If you are notified by email that you must complete the network adequacy sections of the ECP/Network Adequacy Template, submit all providers in the network, including ECP providers, in the Individual Providers and Facilities & Pharmacies tabs. ECP providers must be included even if previously submitted in the ECP tabs. Include providers in another state that are part of the network but may be within the time and distance allowed for reasonable access.
- We will not request network adequacy justifications.
- If we require you to submit an Access Plan with Cover Sheet, we will notify you by email. Upload access plans as supporting documents, as specified in the Supporting Documents table at the end of this section.

<table>
<tr><td style="text-align:center">Additional Resources</td></tr>
</table>

- There are supporting documents for this section.
- There are instructional videos for this section.
- There are templates for this section.

4. Detailed Section Instructions

The ECP/Network Adequacy section of the HIOS Issuer Module contains two questions (the numbering corresponds to the HIOS screens). You must respond to all attestations in the Issuer Module.

<table>
<tr><td colspan="3" style="text-align:center">ECP/Network Adequacy Question 1</td></tr>
<tr>
<td>Does the applicant meet the General ECP Standard or the Alternate ECP Standard (as defined in the annual Letter to Issuers)?</td>
<td>To meet the General ECP Standard, the applicant has:

◆ contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;
◆ 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
◆ 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).</td>
<td>To meet the Alternate ECP Standard, the applicant has:

◆ contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network and
◆ 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).</td>
</tr>
</table>

ECP/Network Adequacy Question 1 Response	
Yes	Answer **Yes** if you meet the ECP requirements listed above.
No	Answer **No** if you do <u>not</u> meet the ECP requirements listed above. If you answer **No**, you are required to submit a supplemental ECP response.

ECP/Network Adequacy Question 2	
Does the applicant use a provider network (and is therefore required to submit an ECP/Network Adequacy Template)?	Answer **Yes** if you are required to upload an ECP/Network Adequacy Template. Answer **No** if you are <u>not</u> required to upload an ECP/Network Adequacy Template.

Figure 1E-1. ECP/Network Adequacy Application Section

Use the ECP/Network Adequacy Template to identify each provider (ECP or Network Adequacy) and any networks to which it belongs. Download the ECP/Network Adequacy Template and save a copy of the template to your local machine. Ensure macros are enabled before completing the ECP/Network Adequacy Template. Complete all required fields, which are identified with an asterisk (*).

See Figure 1E-2 for a sample completed User Control tab.

Figure 1E-2. Sample User Control Tab

User Control Tab	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Source System	Select the name of the system used to submit the QHP Application: ◆ **HIOS**—if you are an FFE issuer. ◆ **SERFF**—if you are an issuer in a state performing plan management functions.
State	Use the drop-down menu to select the state in which you are applying to offer QHPs.
Is this an Alternate ECP Standard Issuer?	Choose from the following: ◆ **Yes**—if you are an Alternate ECP Standard issuer as described under 45 CFR 156.235(b). ◆ **No**—if you are a General ECP Standard issuer.

Create Individual Provider (MD/DO) Tab: Click **Create Individual (MD/DO) Tab** to create the Individual Provider1 tab (clicking this button more than once creates multiple tabs, such as Individual Providers2, Individual Providers3, etc.). We will only collect individual provider data from issuers participating in the continued network breadth pilot project for PY2022. Do not click **Create Individual (MD/DO) Tab** unless you have been notified by email to submit these data. Note: When populating the **Individual (MD/DO) Tab**, submit all providers in the network, including ECP providers even if you have also submitted them in the ECP tabs.

Create Facility, Pharmacy, Non-MD/DO Tab: Click **Create Facility, Pharmacy, Non-MD/DO Tab**. This action creates the Facilities & Pharmacies1 tab (clicking this button more than once creates additional tabs named Facilities & Pharmacies2, Facilities & Pharmacies3, etc.). We will only collect facility provider data from issuers

participating in the continued network breadth pilot project for PY2022. <u>Do not</u> click **Create Facility, Pharmacy, Non-MD/DO Tab** unless you have been notified by email to submit these data. Note: When populating these tabs, submit all providers in the network, including ECP providers, even if you have also submitted them in the ECP tabs.

Import Network IDs: Click **Import Network IDs** to import data from the Network ID Template (please refer to Section 2A: Network ID for detailed instructions on this template). Once the Network ID Template is imported, it will automatically populate networks into the *Network IDs* field as a drop-down menu in the Facility ECPs, Individual ECPs, Individual Providers, and Facilities & Pharmacies tabs.

ECPs:

Select ECPs Tab	Steps
Filter ECPs	You can filter the columns in the Select ECPs tab to make selecting ECPs easier. For example, you might filter the Site State column to show only ECPs available in your state or filter Column F (ECP Category) to display only dental providers if you are an SADP-only issuer.
Add ECPs	Double-click anywhere on the row for the ECPs you want to add to the ECP tabs. Once selected, the row will be highlighted in blue and **add** will appear in *Add ECP?* Continue selecting the ECPs until all contracted ECPs from the ECP list are selected. ◆ To unselect an ECP, double-click on the selected row a second time. The blue highlighting will be removed, and the ECP will not be added to the ECP tabs. ◆ To clear <u>all</u> selected ECPs, click **Clear All** at the top of the tab. All highlighted ECPs will be deselected and will not be added to the ECP tabs. ◆ To show only ECPs that have been selected, click **Show Selected ECPs** at the top of the tab. To show all ECPs, click **Show All ECPs**.
Insert ECPs	◆ Click **Insert Selected ECPs**. The selected ECPs will be added to the Facility ECPs tab (providers with more than one full-time-equivalent [FTE] practitioner in the Number of Medical FTEs and the Number of Dental FTEs and more than one inpatient hospital bed in the Hospital Bed Count) or 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. You must complete any field within the Facility ECPs tab and Individual ECPs tab that is not populated from the Select ECPs tab before submitting the template. ◆ 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 Code, county, and ECP category. ◆ 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 Code, county, and ECP category.

See Figure 1E-3 for a sample Select ECPs tab.

Figure 1E-3. Sample Select ECPs Tab

	A	B	C	D	E	F	G	H	I	J
			Show All ECPs	Clear All	Show Selected ECPs	Insert Selected ECPs	To show all ECPs, press the 'Show All ECPs' button or Ctrl + Shift To select an ECP, navigate to the corresponding row in the 'Add I To clear all selected ECPs, press the 'Clear All' button or Ctrl + S To show selected ECPs, press the 'Show Selected ECPs' button o To insert selected ECPs, press the 'Insert Selected ECPs' button			
	Add ECP?	Row Number	Site Name	Organization Name	National Provider Identifier	ECP Category (General ECP Standard Issuers Only)	Hospital Bed Count	Number of Medical FTEs	Number of Dental FTEs	Site Street Address 1
		CO-001999	Peak Vista Community Health Cente	PEAK VISTA COMMUNITY HEALTH (	1619224987	Federally Qualified Health Centers	0	1	0	12050 Falcon Hwy
	ADD	CO-002000	GRAND AVENUE HOMELESS CLINIC	PUEBLO COMMUNITY HEALTH CEN	1144589425	Federally Qualified Health Centers	0	1	0	1008 N Grand Ave
		CO-002001	Pueblo City and County Health Depa	Pueblo City and County Health Dep:	1245228022	Family Planning Providers, Sexually Transmitte	0	2	0	101 W 9th St
	ADD	CO-002002	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1396098828	Federally Qualified Health Centers	0	1	0	1050 35th Ln
		CO-002003	PARK HILL CLINIC	PUEBLO COMMUNITY HEALTH CEN	1164468336	Federally Qualified Health Centers	0	9	0	1302 E 5th St
	ADD	CO-002004	O'ROURKE DENTAL CLINIC	PUEBLO COMMUNITY HEALTH CEN	1245275932	Dental Providers	0	0	7	2030 Lake Ave
		CO-002005	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1700139813	Federally Qualified Health Centers	0	1	0	216 E Orman Ave
	ADD	CO-002006	Centennial HS SBWC	PUEBLO COMMUNITY HEALTH CEN	1720432610	Federally Qualified Health Centers	0	1	0	2525 Mountview Dr
		CO-002007	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1770529950	Federally Qualified Health Centers	0	26	0	300 Colorado Ave
	ADD	CO-002008	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1013261023	Federally Qualified Health Centers	0	1	0	625 N Monument Ave
		CO-002009	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1649524653	Federally Qualified Health Centers	0	1	0	9 Macneil Rd
	ADD	CO-002010	Pueblo Community College Health C	PUEBLO COMMUNITY HEALTH CEN	1316466816	Federally Qualified Health Centers	0	1	0	900 W Orman Ave
		CO-002011	Rangely District Hospital	Rangely Hospital District	1063430346	Inpatient Hospitals (other than children's hosp	18	0	0	225 Eagle Crest St
	ADD	CO-002012	Rangely Family Medicine	Rangely District Hospital	1730108747	Dental Providers, Family Planning Providers, F	0	4	1	225 Eagle Crest St
		CO-002013	MOUNTAIN FAMILY HEALTH CENTE	MOUNTAIN FAMILY HEALTH CENTE	1578862983	Dental Providers, Federally Qualified Health C	0	2.75	2.5	195 W 14th
		CO-002014	Grand River Health	Grand River Health	1649218991	Inpatient Hospitals (other than children's hosp	12	0	0	501 Airport Rd
		CO-002015	Grand River Primary Care	Grand River Health Primary Care	1124074042	Rural Health Clinics	0	25	0	501 Airport Rd

User Control | **Select ECPs** | Facility ECPs | Individual ECPs | Specialty Types | County Names | Errors

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

Facility ECPs Tab	Steps
Network IDs	Select the network IDs for each ECP. You may select multiple network IDs for each ECP, as applicable. If you are a dual-product issuer, you must create separate network IDs for your medical and dental plans.
Hospital Bed Count	Enter the number of inpatient hospital beds reported by each provider at each site location, as reflected in Column G (Hospital Bed Count) of the Select ECPs tab.
Number of Medical FTEs	Enter the number of medical FTEs that are included in the identified provider networks for each ECP facility with the issuer you have 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 provider at each site location, as reflected in Column H (Number of Medical FTEs) 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 you have 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 provider at each site location, as reflected in Column I (Number of Dental FTEs) of the Select ECPs tab.

See Figure 1E-4 for a sample completed Facility ECPs tab.

Figure 1E-4. Sample Facility ECPs Tab

Remove ECP?	Row Number	National Provider Identifier (NPI)	Facility Name	Provider Name	ECP Category (General ECP Standard Issuers Only)*	
					To select all ECPs, press the 'Select All' button or Ctrl + Shift + A. To clear all ECPs, press 'Clear All' button or Ctrl + Shift + C. To select an ECP, navigate to the corresponding row in the 'Remove EC To remove selected ECPs, press the 'Remove Selected ECPs and Blan	
	CO-002004	1245275932	PUEBLO COMMUNITY HEALTH CENTER	O'ROURKE DENTAL CLINIC	Dental Providers	2030 Lake Ave
	CO-002012	1730108747	Rangely District Hospital	Rangely Family Medicine	Dental Providers, Family Planning Providers, Federally Qualified Health Centers, Other ECP Providers, Outpatient Hospital Clinics	225 Eagle Cres

Buttons: Select All | Clear All | Remove Selected ECPs and Blank Rows

Tabs: User Control | Select ECPs | **Facility ECPs** | Individual ECPs | Specialty Types | County Names | Errors

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: ◆ **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. You 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. You may select multiple network IDs for each ECP, as applicable. If you are a dual-product issuer, you must create separate network IDs for your medical and dental plans.
Number of Medical FTEs	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: MD, DO, PA, and 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 provider at each site location, as reflected in Column H (Number of Medical FTEs) 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: DMD and 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 provider at each site location, as reflected in Column I (Number of Dental FTEs) of the Select ECPs tab.

See Figure 1E-5 for a sample completed Individual ECPs tab.

Figure 1E-5. Sample Individual ECPs Tab

	A	B	C	G	I	J	K
			Select All	Clear All	Remove Selected ECPs and Blank Rows		To select all ECPs, press the 'Select All' button or Ctrl + Shift + A. To clear all ECPs, press 'Clear All' button or Ctrl + Shift + C. To select an ECP, navigate to the corresponding row in the 'Remove ECP?' column and To remove selected ECPs, press the 'Remove Selected ECPs and Blank Rows' button

Remove ECP?	Row Number	National Provider Identifier (NPI)	Name of Provider	Physician/Non Physician*	Specialty Type (area of medicine)*	Provider Entit
	CO-002000	1144589425	GRAND AVENUE HOMELESS CLINIC			PUEBLO COMMUNITY HEALTH
	CO-002002	1396098828	Pueblo Community Health Center			PUEBLO COMMUNITY HEALTH
	CO-002006	1720432610	Centennial HS SBWC			PUEBLO COMMUNITY HEALTH
	CO-002008	1013261023	Pueblo Community Health Center			PUEBLO COMMUNITY HEALTH
	CO-002010	1316466816	Pueblo Community College Health Clinic			PUEBLO COMMUNITY HEALTH

User Control | Select ECPs | Facility ECPs | **Individual ECPs** | Specialty Types | County Names | Errors

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 **Remove Selected ECPs and Blank Rows** to remove the ECP from the template.

Proposing networks without ECPs: If you are proposing networks without ECPs, you will follow a new process starting in PY2022. From the Select ECP tab, scroll to the end of the list to the record identified as "ZZ-000001" and double click anywhere in this row to add the dummy record to the Facility ECPs tab. Then enter the values in Table 1E-1 in the Facility ECPs tab to complete the dummy record entry as shown in Figure 1E-6.

Table 1E-1. Dummy Data Information

Facility ECPs Tab	Steps
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 health professional shortage area (HPSA) tab that is in the same state in which the service area is located.
Network IDs	Using the drop-down menu, select any network IDs associated with the network that does not have an available ECP.

Figure 1E-6. Sample Dummy Record

	A	B	C	D	E	F	
			Select All	Clear All	Remove Selected ECPs and Blank Rows		To select all ECPs, press the 'Select All' button or Ctrl + Shift + A. To clear all ECPs, press 'Clear All' button or Ctrl + Shift + C. To select an ECP, navigate to the corresponding row in the 'Remove EC To remove selected ECPs, press the 'Remove Selected ECPs and Blan

Remove ECP?	Row Number	National Provider Identifier (NPI)	Facility Name	Provider Name	ECP Category (General ECP Standard Issuers Only)*	
	ZZ-000001	0000000000	ZZZZZ	ZZZZZ	Other ECP Providers	00000

User Control | Select ECPs | **Facility ECPs** | Individual ECPs | Specialty Types | County Names | Errors

Note: Issuers planning to submit write-in ECPs should complete the ECP Write-in Worksheet.

HHS will release the PY2022 Available ECP Write-in List and ECP Write-in Worksheet approximately 2 weeks before each QHP certification submission cycle. These documents will be made available at the QHP certification website. The available ECP Write-in List for purposes of the PY2022 QHP certification process will also be made available within the rolling Draft PY2023 ECP List. If you are a General ECP Standard issuer, you may only write in providers on the PY2022 Available ECP Write-in List.

If you are an Alternate ECP Standard issuer, use the ECP Write-in Worksheet to submit your employed or contracted ECPs located in HPSAs or low-income ZIP Codes. We do not expect these practitioners to submit an ECP petition to be included on the Available ECP Write-in List because such practitioners are either your employees or a single contracted medical group and typically are unavailable to contract with other issuers.

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

ECP Write-in Worksheet	Steps
HIOS ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which you are applying to offer QHPs.
Is this an Alternate ECP Standard Issuer?	Choose from the following: ◆ **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.
Import Network IDs	Click **Import Network IDs** to import data from the Network ID Template (please refer to Section 2A: Network ID 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 PY2022 Available ECP Write-in List. For Alternate ECP Standard issuers reporting ECPs that are not required to submit an ECP provider petition (providers who are employed by the issuer or a single contracted medical group), enter "N/A" in this column.
Provider Name	Enter the provider name as it appears on the PY2022 Available ECP Write-in List.
Site Name	Enter the site name as it appears on the PY2022 Available ECP Write-in List.
Organization Name	Enter the organization name as it appears on the PY2022 Available ECP Write-in List.
NPI	Enter the NPI as it appears on the PY2022 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**.
Hospital Bed Count	Enter the number of inpatient hospital beds reported by the identified provider for each ECP.
Number of Medical FTEs	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: MD, DO, PA, and NP. Decimal values may be entered as appropriate to reflect the contracted number of FTEs.
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: DMD and 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 PY2022 Available ECP Write-in List.
Site Street Address 2	Enter additional street address information as it appears on the PY2022 Available ECP Write-in List, as applicable.
Site City	Enter the city as it appears on the PY2022 Available ECP Write-in List.

ECP Write-in Worksheet	Steps
Site State	Select the site state from the drop-down list, as it appears on the PY2022 Available ECP Write-in List.
Site ZIP Code	Enter the site ZIP Code as it appears on the PY2022 Available ECP Write-in List. For Alternate ECP 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 PY2022 Available ECP Write-in List.
Network IDs	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 **Validate** at the top of the worksheet. The worksheet will highlight cells with errors in red. Correct any errors and click **Validate** again. Repeat until a message appears indicating that no validation errors were found.
Export the worksheet	Click **Export** 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 click **Select Folder** in the pop-up window to save a .txt file containing the information from the ECP Write-in Worksheet at that location.
	When ready, submit the .txt file via the ECP/Network Adequacy section within the Issuer Module in HIOS as a Supporting Document labeled "ECP Write-in Worksheet."

Network Adequacy: We will only collect individual and facility provider data from issuers participating in the continued network breadth pilot project for PY2022. If your state has advised you to provide these data to them, please follow your state guidelines. Do not click **Create Facility, Pharmacy, Non-MD/DO Tab** unless you are a medical issuer and we notify you by email to submit these data.

To complete the Individual Providers and Facilities & Pharmacies tabs, follow the steps in the tables below. Note: Include a list of all the providers in each of the proposed networks even if they are outside of the immediate geographic area (such as in contiguous counties or states) and ECP providers, even if they are also included in the ECP tabs.

When performing data integrity checks, we use the provider's primary taxonomy code in the National Plan & Provider Enumeration System (NPPES) database and compare it to the issuer provided Specialty Type. If the primary taxonomy code in NPPES does not align with one of the specialty codes for which a network breadth rating is calculated (Hospital, Primary Care Physician, or Pediatric Primary Care Physician), it will not be included in the calculation. Issuers are encouraged to work with providers to ensure their primary taxonomy code is aligned to the Specialty Type in the submitted template.

Individual Providers Tab	Steps
NPI (required)	Enter the provider's 10-digit NPI in the NPI column. Contact the provider directly to acquire their NPI if you do not know it. If you are unable to obtain the provider's NPI for PY2022, enter **0000000000** (10 zeros) in the NPI field. Ensure the NPI is active in NPPES.
Provider Name Prefix	Enter the prefix for the provider, such as "Dr."
First Name of Provider	Enter the provider's first name.
Middle Initial of Provider	Enter the provider's middle initial.
Last Name of Provider	Enter the provider's last name. If a provider has multiple office locations, each with a unique address, add a number to the provider's last name to distinguish each location, for example, Last Name-001.
Suffix of Provider	Enter the provider suffix, as applicable, such as "Jr." or "Sr."

Individual Providers Tab	Steps
Physician/Non-Physician	Indicate the type of provider. Choose from the following: ◆ **Physician**—if the provider is a physician practitioner. ◆ **Non-Physician**—if the provider is a non-physician practitioner.
Specialty Type (area of medicine)	From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, select all specialties in the same record. ◆ The template does not allow direct entry into this field. However, you may copy and paste data into the template if the specialty type names match how they appear in the Specialty Types tab data, such as **001 General Practice**. Errors will appear if pasted data do not exactly match the specialty type format used in the Individual Providers tab. ◆ If you 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 is not listed in the Specialty Types tab, please select specialty type **000 OTHER** from the drop-down menu.
Street Address	Enter the provider's street address. If the provider has multiple locations, enter each street address in a separate row. <u>Do not</u> use a PO box in the address, because it cannot be geocoded for analysis. All providers with a PO box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, if 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 Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP	Enter the ZIP Code where the provider is located. ZIP Codes must include either five (12345) or nine (12345-6789) digits.
Network ID	When entering network IDs, use the same network IDs as those assigned in the Network ID Template and the Plans & Benefits Template. If you are a dual-product issuer, you must create separate network IDs for your 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, select all networks in the same record.

See Figure 1E-7 for a sample Individual Providers tab.

**Figure 1E-7. Sample Individual Providers Tab**
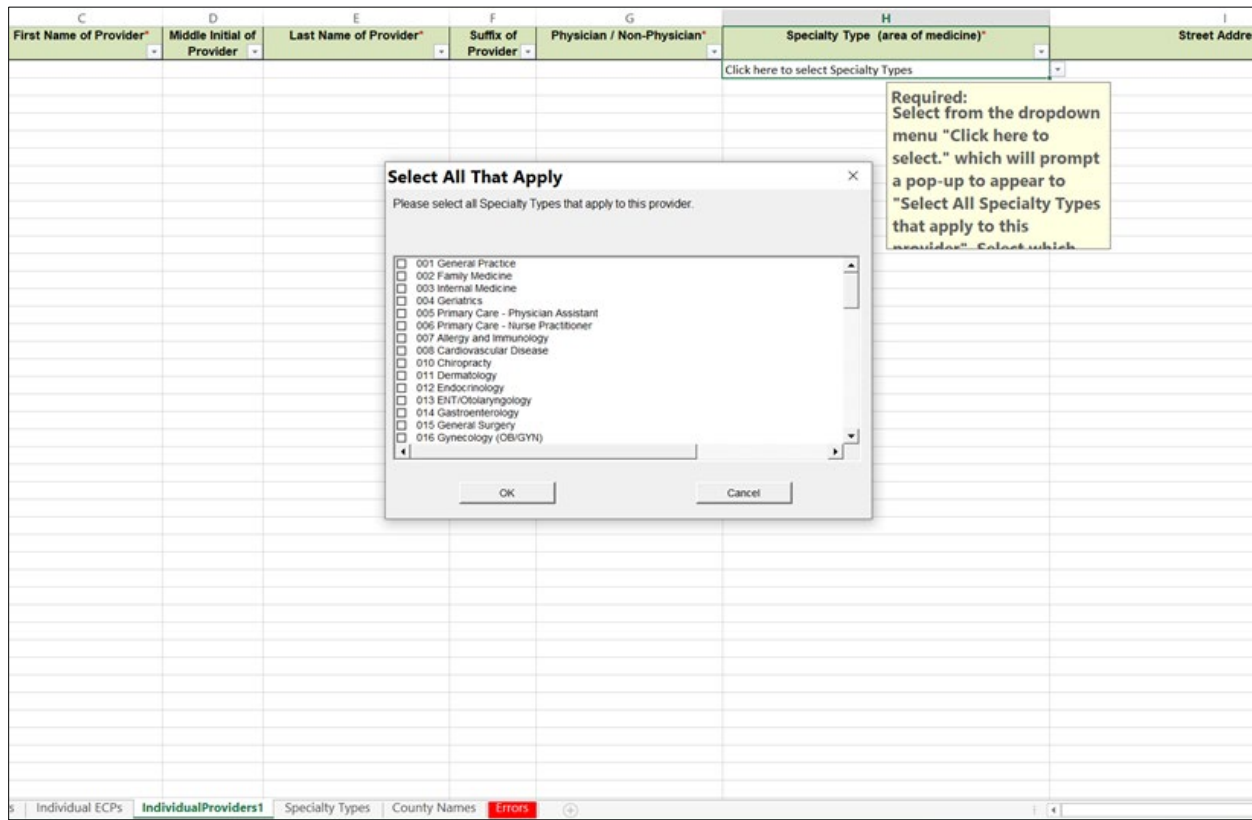
Individual Provider tabs can be removed from the template by using the **Delete** function, located in Column P of the User Control tab. Note that once a tab is deleted, it cannot be recovered, so save the template before deleting tabs.

Facilities & Pharmacies Tab	Steps
NPI	Enter the provider's 10-digit NPI. Contact the provider directly to acquire their NPI if you do not know it. If you are unable to obtain the provider's NPI for PY2022, enter **0000000000** (10 zeros) in the NPI field. Ensure that the NPI is active in the NPPES database.
Facility Name	Enter the name of the facility or pharmacy.
Facility Type	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. ◆ The template does not allow direct entry into this column. You may copy and paste data into the template if the facility type names match in the Specialty Types tab, such as **040 General Acute Care Hospital**. Errors will appear if pasted data do not exactly match the facility type format used in the Facilities & Pharmacies tab. ◆ If entering more than one facility type, each facility type must be separated by a comma and a space. ◆ If the facility type is not listed in the Specialty Types tab, please select facility type **000 OTHER** from the drop-down menu.
Street Address	Enter the provider's street address. This is the address where an enrollee will obtain services and not the provider's corporate location unless the addresses are the same. If the provider has multiple locations, enter each street address in a separate row. Do not use a PO box in the address because it cannot be geocoded for analysis. All providers with a PO box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, as applicable.

Facilities & Pharmacies 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 FIPS code when entering the county name.
ZIP	Enter the ZIP Code where the provider is located. ZIP Codes must include either five (12345) or nine (12345-6789) digits.
Network ID	When entering network IDs, use the same network IDs as those assigned in the Network ID Template and Plans & Benefits Template. If you are a dual-product issuer, you must create separate network IDs for your 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, select all networks in the same record.

See Figure 1E-8 for a sample Facilities & Pharmacies tab.

Figure 1E-8. Sample Facilities & Pharmacies Tab
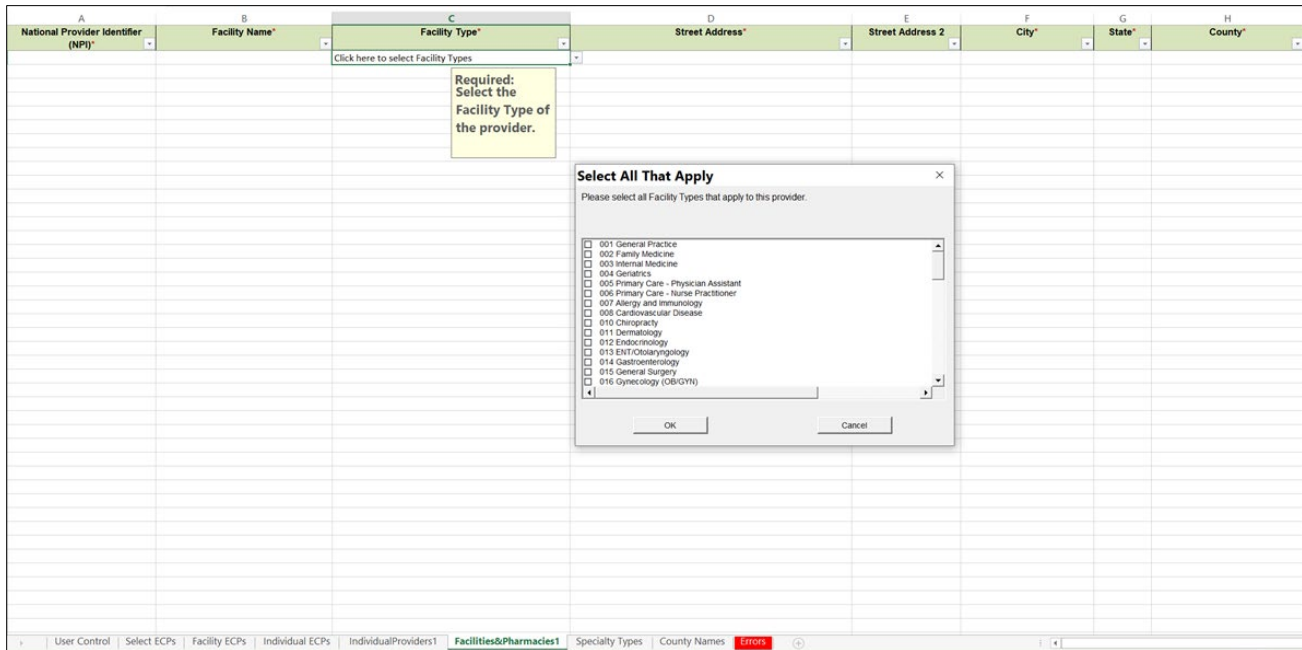
Reference information is provided in the three tabs listed below:

- The Specialty Types tab contains the specialty/facility and pharmacy types that can be added into the ECP/Network Adequacy Template.

- The County Names tab contains the county names that are used and accepted in the ECP/Network Adequacy Template.

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 creates 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 you complete the ECP/Network Adequacy Template, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** on the User Control tab. The validation process identifies any data issues that need to be resolved. If no errors are identified you will receive the message "No validation errors were identified. Validation is complete," indicating you may finalize the template.
Errors	Errors will appear on the Errors tab, which shows the data element, cell location, and the validation error message of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Create Documents	Once all validations are complete, click **Create Documents** on the User Control tab to create a separate .XML file for each tab in the workbook and compress all files into one .zip file. Upload the .zip file into the ECP/Network Adequacy section of the Issuer Module in HIOS.
Save Template	**Save** the .XML files and template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML files for easier reference.
Upload Template	Upload the saved .XML files in the ECP/Network Adequacy section of the Issuer Module in HIOS. Refer to 1. Issuer Module for guidance.

After uploading the necessary ECP/Network Adequacy file, you may need to upload supporting documentation. These documents must be labeled using the drop-down menu designations (**Network Adequacy Access Plan with Cover Sheet**, **Supplemental ECP Response – Health**, **Supplemental ECP Response – Dental**, **ECP Write-In Worksheet**, or **Other**.

Figure 1E-9. Uploading Supporting Documentation

Supporting Documents	Steps
General ECP Standard Issuers Supplemental ECP Response Form and Justification	◆ You must submit an ECP supplemental response form if any <u>one of the following applies</u>: ▪ You do not contract with at least 20 percent of the available ECPs in each applicable service area. ▪ You do 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. ▪ You do 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.

Supporting Documents	Steps
	◆ Include your HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20200601).
Alternate ECP Standard Issuers Supplemental ECP Response Form and Justification	◆ You must submit an ECP supplemental response form if any <u>one of the following applies</u>: ▪ You do not include in each plan network at least 20 percent of available ECPs in each plan service area, with providers located within HPSAs or ZIP Codes in which 30 percent or more of the population falls below 200 percent of the federal poverty line. ▪ You do 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 in each available ECP category in each county in the plan's service area (not applicable to SADP applicants). ◆ Include your HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20200601).

Network Adequacy Cover Sheet and Access Plan	If we notify you by email that your QHPs and SADPs must submit access plans, submit a Cover Sheet and Access Plan that addresses the 11 areas below. The Cover Sheet must provide page numbers for each of the 11 areas in the Access Plan:
	1. Your network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.
	2. Your procedures for making and authorizing referrals within and outside your network, if applicable.
	3. Your process for monitoring and ensuring 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 you use to build your provider network, including a description of the network and the criteria used to select (or tier) providers.
	5. Your efforts to address the needs of covered persons, including children and adults, and 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 your efforts, when appropriate, to have various types of ECPs in your network.
	6. Your methods for assessing the health care needs of covered persons and their satisfaction with services.
	7. Your method of informing covered persons of the plan's covered services and features, including
	    a. the plan's grievance and appeals procedures;
	    b. its process for choosing and changing providers;
	    c. its process for updating the provider directories for each of its network plans;
	    d. a statement of health care services offered, including those services offered via the preventive care benefit, if applicable; and
	    e. its procedures for covering and approving emergency, urgent, and specialty care, if applicable.
	8. Your 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. Your process for enabling covered persons to change primary care professionals, if applicable.
	10. Your proposed plan for providing continuity of care in the event of contract termination with any of your participating providers or in the event of your insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or your insolvency or other cessation of operations and transitioned to other providers in a timely manner.

Supporting Documents	Steps
	11. Your process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at your participating hospitals.
	Note: Merge the Network Coverage Cover Sheet and the Access Plan and submit them as one file if possible. In this case, the file name for access plans should be your HIOS Issuer ID followed by "Access Plan" and necessary additional information (for example, 12345_Access_Planv3). If you submit a Cover Sheet as a separate file from the Access Plan, the file name should be your HIOS Issuer ID followed by "Access Plan Cover Sheet" and necessary additional information (for example, 12345_Access_Plan_Cover_Sheetv3).

After entering all data, click **Save** to ensure no data are lost. This completes the Instructions for the Issuer Module portion of the PY2022 QHP Application. The next section of the Instructions for the PY2022 QHP Application is the Benefits and Service Area Module.

2. 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 necessary to complete the Benefits and Service Area Module) and Benefits Validator (an individual who verifies that all sections of the Benefits and Service Area Module are accurate). Both roles can cross-validate data elements to ensure consistency throughout the application, but only the Benefits Validator can submit the application after cross-validation ends.

You must download the Plans & Benefits Template Add-In file and the Actuarial Value Calculator (AVC) file to successfully complete this module. The Plans & Benefits Template Add-In file contains all the macros for the Plans & Benefits Template. We strongly encourage you to save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template. Use the AVC file from the [QHP certification website](#) to calculate and import the actuarial value (AV) for each medical plan in the Plans & Benefits Template. Always download the latest version of the Plans & Benefits Add-In and AVC files and save them to a new folder. Do not rename the Add-In files.

This module is organized by its application sections, and consists of the Summary page, Data Submitter page, Data Validator page, and Final Submission page.

The Summary page is the first page visible when navigating to the Benefits and Service Area Module. You will use it to start a new application, resume a pending application, or view a submitted application for the HIOS Issuer IDs to which you have access.

The Data Submitter page consists of tabs navigating through the sections within the Benefits and Service Area Module: Plans & Benefits, Network ID, Service Area, Prescription Drug, and Transparency in Coverage. Within each tab, you will complete and submit the templates and supporting documentation required for the Qualified Health Plan (QHP) Application.

The Data Validator page consists of the same tabs as the Data Submitter page, but provides options to view the data read-only and to download the supporting documentation to validate its accuracy. This section allows Benefits Validators to upload supporting documentation and answer supplemental responses through the Health Insurance Oversight System (HIOS) (see Figure 2-1 and Figure 2-2).

The Final Submission page allows the Benefits Submitter and Benefits Validator to cross-validate data between modules, and allows the Issuer Validator to submit the QHP Application.

Each tab provides information that you need to enter to create a new application or edit an existing application. You must complete all sections listed in the lower left part of the Data Submitter page before beginning work on the Data Validator page.

Figure 2-1. Data Submitter Page

Upload Documentation

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				
*Plan & Benefits Template (Individual)	Upload				
Dental Plan & Benefits Template (SHOP)	Upload				
Dental Plan & Benefits Template (Individual)	Upload				
*Network ID Template	Upload				
*Service Area Template	Upload				
Prescription Drugs Template	Upload				
Select document type	Upload				

Showing 1 to 8 of 8 entries

Add Another Document

Figure 2-2. 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.xlsm		02/17/2015 3:53:01 PM	Complete
*Plan & Benefits Template (Individual)	87296_NC_2016_PB_Med_Ind.xlsm		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_PrescriptionDrug.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, you must assign each of your provider networks—groups of providers providing services in an area—to network IDs.

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. List of provider networks.

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the Network ID Section
◆ If you are a dual-product issuer, you must create two different network IDs, one each for QHPs and stand-alone dental plans (SADPs), regardless of whether the specific network is intended to serve both plan types.
◆ If you are a dual-product issuer, you must use the word "dental" in the network area name for your dental service area to distinguish the dental network from the QHP network.
◆ The Network ID Template syncs to the Plans & Benefits Template. Each plan identified in the Plans & Benefits Template must list the network ID that is associated with it.

Additional Resources
◆ There are no supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

Follow these 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 **Create Network IDs**. Enter the number of networks when prompted and select **OK**. This button automatically generates the network IDs based on the number of networks specified.
Network Name	Enter a network name. Dual-product issuers must use the word "dental" in the dental network name to distinguish the dental network from the QHP network.
Network ID	Select a network ID from the drop-down menu. The network IDs consist of the state abbreviation, the letter "N," and a sequenced number (such as MDN001 or MDN002). If you are a dual-product issuer, you must create separate network IDs for your QHP and dental networks.

Repeat these steps for each additional network ID.

See Figure 2A-1 for a sample completed Network ID Template.

Figure 2A-1 Sample Network ID Template

2022 Network Template v11.0	All fields with an asterisk (*) are required.
Validate	To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.
Finalize	Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.
	Network IDs will populate in the drop-down box in Network ID column.
	Use each Network ID only once.
HIOS Issuer ID*	
Issuer State*	
Create Network IDs	
Network Name* Required: Enter the Network Name	**Network ID*** Required: Select the Network ID
Smith Network	VAN001

After entering all data, click **Save** to ensure no data is lost. Once the Network ID Template is completed, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** 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 reason for 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 **Finalize** in the template to create the .XML version of the template you will upload in the Network section of the Benefits and Service Area Module.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Network section of the Benefits and Service Area Module in HIOS. Refer to 2. Benefits and Service Area Module for details on how to complete this step.

The next section of the Instructions for the plan year (PY) 2022 QHP Application is Service Area.

Section 2B: Service Area

1. Introduction

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

In the Service Area section, you identify the service areas associated with your QHPs, SADPs, or both, by state and county. You must submit the Service Area Template as part of your QHP Application.

You must identify proposed service areas in your application to indicate the geographic coverage of each QHP, SADP, or combination and to demonstrate compliance with the county integrity requirements under 45 Code of Federal Regulations (CFR) 155.1055. The service area of a plan is the geographic area where it accepts members, if it limits membership based on where people live.

The Department of Health and Human Services (HHS) prefers only service areas covering full counties. If you propose a service area covering a partial county, you must provide a partial county supplemental response.

The Service Area section of the QHP Application comprises three parts:

1. A template for identifying your proposed service area and the included counties and ZIP Codes, if you do not intend to cover the entire state.[1]

2. A detailed Partial County Supplemental Response Form, if you are proposing a plan covering a partial county.

3. Written evidence from the appropriate Federally-facilitated Exchange (FFE) state regulator indicating that the state has approved your proposed plan to cover a partial county.

2. Data Requirements

To complete the template for this section, you will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Names and IDs for proposed service areas to be associated with your QHPs or SADPs
4. Names of counties that you are applying to cover if you do not include an entire state in a service area
5. ZIP Codes in any county that you are applying to cover if you do not include an entire county in a service area.

3. Quick Reference

Key Changes for 2022
◆ You must create separate service area IDs for your Individual market service areas and your Small Business Health Options Program (SHOP) market service areas. If you submit via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates and Forms Filing (SERFF) you must use the same Service Area Template across all binders <u>or</u> ensure that no service area IDs repeat across the binders.

Tips for the Service Area Section
◆ You may not change a service area after the initial submission deadline unless you submit a data change request to do so and make this change during the timeframe we have specified. This applies even if you submit via SERFF and make the change in response to an error issued by the state. See the Service Area Data Change Request Process in the **Review Periods, Revision Process, and Certification** section for more information.
◆ If you are a dual-product issuer, you must create two different service area IDs, one each for QHPs and SADPs, regardless of whether the service area is intended to serve both plan types.

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[1] The columns for these data appear in the Excel template when **Yes** is selected for Column E.

Tips for the Service Area Section
◆ If you are a dual-product issuer, you must use the word "dental" in the service area name for your dental service area to distinguish the dental service area from the QHP service area.
◆ If you offer plans in the Individual and SHOP markets, you must create separate service area IDs for each market, regardless of whether the service area is intended to serve both markets.

Additional Resources
◆ There are <u>supporting documents</u> for this section.
◆ There are <u>instructional videos</u> for this section.
◆ There are <u>templates</u> for this section.

4. Detailed Section Instructions

Follow these steps 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 you intend to offer coverage using the drop-down menu.
Service Area ID	Click **Create Service Area IDs** at the top of the Service Area Template and enter the total number of desired service areas for the identified state. The template will generate and add the requested number of service area IDs to the Service Area ID drop-down menu. For example, if you enter "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, request one service area. The service area ID consists of the state abbreviation plus an "S" and then a sequenced number (for example, AZS001 or AZS002).
	Note: If you submit via SERFF, click **Create Service Area IDs** and enter the number of service area IDs you need to ensure no two templates use the same service area ID. For example, if the Individual market needs three service area IDs and the SHOP market needs two service area IDs, enter "5" for the total number of service areas.
	Each plan can only be associated with one service area ID, but a service area ID can be associated with multiple plans. In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.
Service Area Name	Enter a name for the service area selected.
	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 plan name.
	If you are a dual-product issuer, you must use the word "dental" in the name for your dental service area to distinguish the dental service area from the QHP service area.
	The service area name will not display to the public on HealthCare.gov.
State	Choose from the following:
	◆ **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.
	Note: The same service area ID <u>cannot</u> be used for both a service area that covers the entire state <u>and</u> a service area that covers only certain counties in the state.
County Name	Use the drop-down menu to select the name of each county included in the identified service area if you indicated that the identified service area does not cover the entire state.
	If a service area includes multiple counties, you must add a new row for each new county using the same service area ID and service area name.

Service Area Template	Steps
	If your service area counties are not in the drop-down menu, contact the Marketplace Service Desk by phone at 855-267-1515 or by email at CMS_FEPS@cms.hhs.gov.
Partial County	Choose from the following: ◆ **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 Service Area ZIP Code(s) column and a Partial County Justification Filename column will appear on the template.
Service Area ZIP Code	Enter the five-digit ZIP Codes (12345) you propose to cover in the partial county. If you are entering more than one ZIP Code, separate each ZIP Code with a comma.
Partial County Justification Filename	Save the Partial County Justification Form using the naming convention in Table C-1. For example, "12345_AZ_service_area_partial_county."

See Figure 2B-1 for a sample completed Service Area Template.

Figure 2B-1. Sample Service Area Template

If you request to serve a partial county (i.e., if you select **Yes** in Column E of the Service Area Template), you must complete the following steps.

Partial County Justification Supplemental Response
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. You must submit a detailed supplemental response substantiating why you will not serve the entire county for each exception you request. You must justify how the partial county service area is necessary, non-discriminatory, and in the best interests of consumers and the Exchange program, consistent with 45 CFR 155.1055.
Answer the questions on the Partial County Supplemental Response Form. If you do not respond to each of these questions, your partial county request will be denied.
You may request partial county service areas only if you have received state authorization. If you request a partial county service area in an FFE state and submit the QHP Application via HIOS, provide written evidence that the appropriate state regulator has authorized your partial county service area, such as email correspondence with the state that lists the specific ZIP Codes in the partial county requested. If your state performs plan management functions, you must submit a partial county supplemental response but are not required to submit evidence of state approval. If the state transmits the request, that will serve as state approval.
After completing the supplemental response form, do the following: ◆ Combine written evidence that the appropriate FFE 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 naming convention in Table C-1. For example, "12345_AZ_service_area_partial_county." Enter this file name in Column G, "Partial County Justification Filename," of the Service Area Template. ◆ Upload the combined document in the Plans & Benefits section of the Benefits and Service Area Module in HIOS using the document upload functionality. Select **Service Area Justification** from the Document Type drop-down menu.

After entering all data, click **Save** to ensure no data are lost. Once the Service Area Template is completed, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** 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 reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML version of the template you will upload in the Service Area section of the Benefits and Service Area Module in HIOS.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Service Area section of the Benefits and Service Area Module in HIOS. Refer to 2. Benefits and Service Area Module for details on how to complete this step.

When establishing service areas, consider existing health care delivery markets in the states in which you are applying to offer plans. If the distance people in a rural county travel to see a provider is consistent with state-permitted practices, it may not be necessary to have a contracted provider in all parts of a rural county. In such cases, you might consider establishing a service area for the entire state to enable members in rural parts of the county to see providers in other ZIP Codes. Alternatively, you might exclude an entire county from a service area if no providers are available in the excluded ZIP Codes.

A service area can be associated with multiple plans. For example, you might have five plans and four service areas as follows: 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. Create one template for all service areas and identify each service area with a unique service area ID. Complete the Network ID Template and create a unique network ID for each network. The Plans & Benefits Template 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, you may have a single state-wide network that is identified with a network ID and assigned to all of your plans, but have two service area IDs that are each made up of half the state and each assigned to a different plan.

The Exchange does not require your service area to cover a complete rating area, but you are bound by state service area requirements. Carefully review state guidance on this topic to ensure your 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.

If your state performs plan management functions and you file via SERFF, we strongly encourage you to submit a Microsoft Excel version of your Service Area Template.

The next section of the Instructions for the PY2022 QHP Application is Prescription Drug.

Section 2C: Prescription Drug

1. Introduction

In the Prescription Drug section, you will create cost-sharing values for each tier of drug benefits and for specific drugs included in the formulary and select the drugs that will be offered at each tier level. These instructions do not apply to SADP-only issuers.

2. Data Requirements

To complete this section, you will need the following:

1. A drug list with RxNorm Concept Unique Identifiers (RXCUIs) and formulary tier numbers. You may offer drugs that do not have associated RXCUIs, but may not include such drugs on the Prescription Drug Template.[1]

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the Prescription Drug Section
◆ RXCUIs should have one of the following Term Types (TTYs): 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.
◆ Each drug list may have only one tier structure, as indicated by number of tiers and drug tier types, and all formularies associated with each drug list must be identical. The .XML file 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.

Additional Resources
◆ There are supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

Complete the Drug Lists worksheet before you fill out the Formulary Tiers worksheet in the template. See Figure 2C-1 for a sample completed Drug Lists worksheet.

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[1] Pursuant to 45 CFR 156.122(a)(3), for plan years beginning on or after January 1, 2018, a health plan does not provide Essential Health Benefits (EHBs) unless it uses a pharmacy and therapeutics committee that meets certain standards.

Figure 2C-1. Drug Lists Worksheet

Before entering details for each drug list, enter all RXCUIs included in any of the drug lists into Column A, beginning in Row 9. After entering all of the unique RXCUIs, enter the drug list-specific information in each row.

Drug List	Steps
RXCUI	◆ When selecting RXCUIs to include, use the December 7, 2020, full monthly release of RxNorm data to find a list of valid RXCUIs. To download the file, you will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at the National Library of Medicine. ◆ Find the EHB RX Crosswalk, a reformatted RxNorm database, and state review tools on the Center for Consumer Information and Insurance Oversight (CCIIO) Review Tools page. ◆ RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK. ◆ The drug list should include all drugs on your formulary, even those that are not in a category or class identified in the summary of EHB benchmark information. This includes all drugs you list 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: ◆ **Yes**—if prior authorization is required. ◆ **No**—if prior authorization is <u>not</u> required. If Tier Level is "NA," leave this column blank.
Step Therapy Required	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: ◆ **Yes**—if step therapy is required. ◆ **No**—if step therapy is <u>not</u> required. If Tier Level is "NA," leave this column blank.

To add another drug list, click **Add Drug List** (Figure 2C-2). You must complete the Tier Level, Prior Authorization Required, and Step Therapy Required columns as described above to complete the new drug list.

Figure 2C-2. Add Drug List Button

To remove a drug list, click **Remove Drug List** (Figure 2C-3). Drug lists are removed in reverse order, meaning the last drug list created is removed first. To remove a drug list other than the last drug list created, copy and paste the data from the last drug list into the drug list you wish to delete to overwrite its data, then click **Remove Drug List** to remove the final drug list you have just duplicated.

Delete any unused drug lists that link to formulary IDs that are not linked to a standard component ID in the Plans & Benefits Template. Before deleting a drug list, make sure all remaining formulary IDs link to the correct drug lists.

Figure 2C-3. Remove Drug List Button

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

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Select the state in which the template will apply from the drop-down menu.
Generate Formulary IDs	Click **Create Formulary IDs** to create the formulary IDs. ◆ 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, the letter "F," and a sequenced number (such as ALF001 and ALF002). ◆ Once completed, the formulary IDs appear in a drop-down menu in the Formulary ID column.
Formulary ID	Select the formulary ID from the drop-down menu. ◆ 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. HIOS 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.
Drug List ID	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 Lists worksheet. If the Drug Lists worksheet has not been completed, you must complete it before you can proceed.

2022 QHP Application Instructions

Formulary Tiers	Steps
Number of Tiers	Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary must correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created within a tier. All drugs within each tier should have the same cost-sharing structure.
Drug Tier ID	Do not edit the Drug Tier ID column; it is controlled by the template. The template populates this column based on the selection in Number of Tiers and grays out cells that do not apply.
Drug Tier Type	Click the drop-down menu, and select **Click here to select** to open a dialog box. Choose 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 or Medical Service Drugs. ◆ 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, choose the preferred generic tier type. 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. ◆ 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**. Zero Cost Share Preventive Drugs: ◆ When Zero Cost Share Preventive Drugs is selected for a tier, it is the only tier type that can be selected. Classify the Zero Cost Share Preventive Drug tier as Tier 1 if applicable, to represent the lowest-cost tier to the consumer. ◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance information will be set to **$0** and **0 percent**, respectively, when you choose this tier type. The remaining pharmacy benefit types can still be edited. If remaining pharmacy benefits are offered, enter the subsequent cost-sharing values as **$0** and **0 percent**. ◆ If you offer a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, 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, in the plan brochure, and on the formulary web page. Medical Service Drugs: ◆ Use this tier type to indicate that a formulary contains medical service drugs. We recognize that some state benchmarks contain medical service drugs in various categories and classes; a Medical Service Drugs tier can help identify 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 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance 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	This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance. You must indicate whether each tier offers these types of pharmacy benefits, but should only complete the information for the other three pharmacy types if they apply to the given drug tier. The pharmacy benefits are as follows: ◆ 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 Order[2] Pharmacy (Copayment & Coinsurance)

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

Formulary Tiers	Steps
	◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance).
Benefit Offered	Select **Yes** if the pharmacy benefit is offered for the corresponding tier. Otherwise, select **No**.
Copayment	Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use **Not Applicable**, <u>not</u> **No Charge**, for copayment if a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ **$X Copay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—after the consumer pays the copay, 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. You may only select **Not Applicable** for coinsurance and copay if the drug tier type is **Medical Service Drugs**.
Coinsurance	Enter the coinsurance amount for the given pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use **Not Applicable**, <u>not</u> **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, 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. You may only select **Not Applicable** for copay and coinsurance if the drug tier type is **Medical Service Drugs**.

Complete cost-sharing fields in the Prescription Drug Template 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, in the plan brochure, and on the formulary web page.

We will review tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing your formulary tier structure, 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. Subsequent tiers in the formulary structure should 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 Patient Protection and Affordable Care Act (PPACA) must be covered without requiring the consumer to pay a copayment or coinsurance or meet a deductible. For more information on covering preventive services, see the Preventive health services page on HealthCare.gov.

We recommend you place preventive drugs in a separate Zero Cost Share Preventive tier in the Prescription Drug Template. If you have a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, 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, in the plan brochure, and on the formulary web page.

If you have used all seven available tiers, include the zero cost preventive drugs in the lowest-cost tier and clearly identify that these drugs are available at zero cost sharing in the plan brochures and on the formulary

web page; all drugs within the same tier should have the same cost sharing. Alternatively, if one of the seven tiers is a medical service drug tier, replace the medical service drug tier with a zero cost preventive drugs tier.

If you offer a tier with cost sharing of zero that is not a preventive tier, you 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. **Not Applicable** may only be used for copayment and coinsurance in a medical service drug tier.

The Prescription Drug Template does not capture minimum or maximum copay or coinsurance. 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, in the plan brochure, and on the formulary web page.

After entering all data, click **Save** to ensure no data are lost. Once the Prescription Drug Template is completed, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** 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 reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML file of the template you will upload in the Prescription Drug section of the Benefits and Service Area Module in HIOS.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Prescription Drug section of the Benefits and Service Area Module in HIOS. Refer to 2. Benefits and Service Area Module for details on how to upload this file.

The next section of the Instructions for the PY2022 QHP Application is Plans & Benefits.

Section 2D: Plans & Benefits

1. Introduction

In the Plans & Benefits section, you will enter data about your plans, list covered benefits with any quantitative limits or exclusions, and provide cost-sharing values and basic plan variation information for each plan you submit, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. This information is provided via two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet.

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. Completed Network ID Template
2. Service Area Template
3. Prescription Drug Templates (QHP only)
4. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2022
◆ The EHB percent of total premium for SHOP market QHPs is no longer collected in this template.
◆ The EHB percent of total premium calculation should be the multiplicative inverse of the Unified Rate Review Template (URRT) field titled "Benefits in Addition to EHB" when rounded to the fourth decimal point (e.g., 1 divided by Benefits in Addition to EHB).
◆ Explanation is added of how individual market QHP issuers should address defrayal requirements for the portion of premium related to state required benefits in addition to the EHB.
◆ The EHB apportionment for pediatric dental for SHOP market SADPs is no longer collected in this template.

Tips for the Plans & Benefits Section
◆ Download the most recent versions of the 2022 Plans & Benefits Template, Plans & Benefits Add-In file, and AVC from the QHP certification website.
◆ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template so the macros will run properly.
◆ All data elements that we anticipate displaying to Individual market consumers on Plan Compare are identified by a number sign (#) next to the field name in the instructions below.
◆ All data fields required for SADP issuers are identified by an asterisk (*) next to the field name in the instructions below. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variances worksheet, see sections 4.11, 4.20–4.22, 4.24, and 4.25 in this chapter.
◆ All data fields used by the AVC are identified by a caret (^) next to the field name in the instructions below. See Appendix A for additional AVC instructions.
◆ Complete and save the Network, Service Area, and Prescription Drug (QHPs only) Templates before filling out the Plans & Benefits Template. The Plans & Benefits Template requires you to assign a network, service area, and formulary ID (QHPs only) to each plan based on the IDs created in these three templates.
◆ Complete a separate Benefits Package worksheet for each unique benefits package you wish to offer. To create additional benefits packages, click **Create New Benefits Package** under the Plans & Benefits Add-In. *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, and *Dental Only Plan* will auto-populate.
◆ Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost-sharing reduction (CSR) plan variation the issuer wishes to offer.
◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Appendix A for how these values relate to AV.
◆ When a cell is grayed out, it is locked and cannot be edited. HIOS will not process data entered into the cell before it was grayed out.

4. Detailed Section Instructions

If you are asked to enable macros when you open the Plans & Benefits Template, use **Options** on the Security Warning toolbar, and select **Enable this content**. If you enter data before enabling the macros, the template will not recognize those data fields and you will have to reenter them. Once you enable macros, the **Plans and Benefits** ribbon should appear (Figure 2D-1) as a tab on the file's toolbar.

Figure 2D-1. Plans and Benefits Ribbon
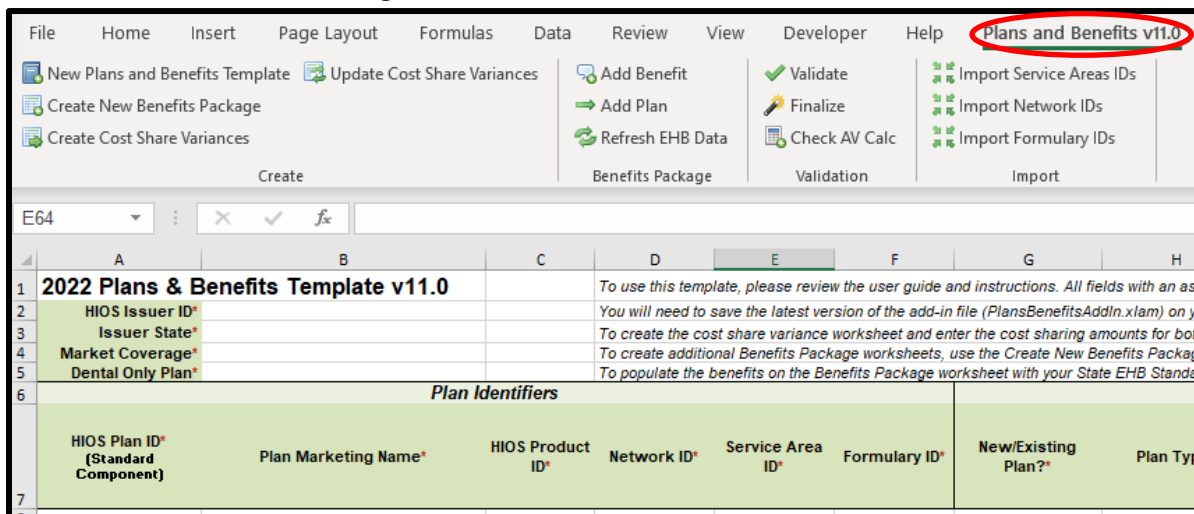
Note: Before proceeding, confirm you have downloaded the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the [QHP certification website](#).

4.1 General Information

Enter your basic issuer information in the fields in the upper left portion of the Benefits Package worksheet (Figure 2D-2). After you enter this information in the first Benefits Package worksheet, it will auto-populate in any additional Benefits Package worksheets you generate.

Figure 2D-2. Plans & Benefits Template
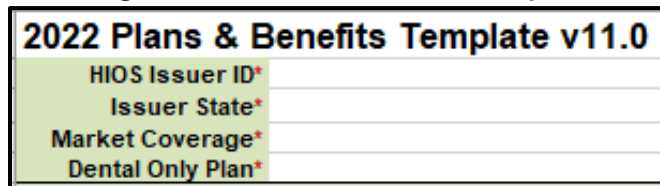
General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which you are licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following: ◆ **Individual**—if the plans are offered on the Individual market. ◆ **SHOP (Small Group)**—if the plans are offered on the SHOP market.

General Plans & Benefits Information	Steps
Dental-Only Plan*	Indicate whether the plans contained in the template are dental-only plans. Choose from the following: ◆ **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 fields from accepting data entry. ◆ **No**—if this is <u>not</u> a dental-only package.

4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data for 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 you intend 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 or an SADP; 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. After you enter each standard plan in the Benefits Package worksheet, the template will automatically create the necessary plan variations in the Cost Share Variances worksheet.

If you run out of empty rows for new plans, click **Add Plan** on the menu bar under the **Plans & Benefits** ribbon. Each benefits package may include up to 50 plans. Create a second benefits package with an identical structure to accommodate additional plans.

Figure 2D-3. Plan Identifiers Section

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.
Network ID*	Click **Import Network IDs** on the menu bar under the **Plans & Benefits** ribbon and select the Network ID Template Excel file you completed previously to import its network ID values, then select the appropriate network ID from the drop-down menu.
Service Area ID*	Click **Import Service Area IDs** on the menu bar under the **Plans & Benefits** ribbon and select the Service Area Template Excel file you completed previously to import its service area ID values, then select the appropriate service area ID from the drop-down menu.
Formulary ID	Click **Import Formulary IDs** on the menu bar under the **Plans & Benefits** ribbon and select the Prescription Drug Template Excel file you completed previously to import its values, then select the appropriate formulary ID from the drop-down menu.

4.3 Plan Attributes

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

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

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following: ◆ **New**—if this is a new plan that was not offered last year. This includes any plan offered last year but not considered to be the "same plan" as described in 45 CFR 144.103. New plans should use a new plan ID that was <u>not</u> used for the 2021 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. Existing plans should use <u>the same</u> plan ID that was used for the 2021 plan year.
Plan Type*#	Select the plan type that best corresponds to plan definitions provided in state law or regulations in your state. Plan type selections must be consistent with your state form-filing submissions. Choose from the following: ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point-of-service) ◆ EPO (exclusive provider organization).
Level of Coverage^*#	Select the metal level of the plan based on its AV. A de minimis variation of −4/+2 percentage points is allowed for standard metal-level plans. 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 on the Exchange, as described in Section 1302(d)(1) of the PPACA. Choose from the following: ◆ **Bronze**—AV of 60 percent ◆ **Expanded Bronze**—AV of 56–65 percent. A plan may use this option if it either covers and pays for at least one major non-preventive service 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. SADPs must complete the *Level of Coverage* field. Selecting **High** or **Low** will allow the template to validate for PY2022. The selection will not display to issuers in Plan Preview or to consumers in Plan Compare, as described in 45 CFR 156.140: ◆ **Low**—AV of 70 percent ◆ **High**—AV of 85 percent.
Design Type*	This field is not applicable for PY2022. All plans should select **Not Applicable** for this field.

Plan Attributes	Steps
Unique Plan Design	Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available by HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix A. Choose from the following: ◆ **Yes**—if unique plan design features cause the AVC to yield an AV result that materially differs from that of other approved methods described in 45 CFR 156.135(b). This indicates the plan is not compatible with the AVC. If you select **Yes** for this reason, upload the Unique Plan Design Supporting Documentation and Justification Form. 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*	Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following: ◆ **On the Exchange**—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select **Both** unless an exception to guaranteed availability applies. ◆ **Off the Exchange**—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange for purposes of the risk corridor program (see 45 CFR 153.500 for more details). ◆ **Both**—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.
Notice Required for Pregnancy	Indicate whether consumers or providers must notify you of a pregnancy before pregnancy benefits are covered. Choose from the following: ◆ **Yes**—if a notice is required before pregnancy benefits are covered. ◆ **No**—if a notice is <u>not</u> required before pregnancy benefits are covered.
Is a Referral Required for a Specialist?#	Indicate whether consumers must be referred to see a specialist. Choose from the following: ◆ **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#	Enter the types of specialists that require a referral if **Yes** is entered for *Is a Referral Required for a Specialist?*
Plan Level Exclusions*	Enter any plan-level exclusions.
Limited Cost-Sharing Plan Variation—Est. Advance Payment	Leave this field blank. This data element is not required for PY2022. As specified in the *2015 HHS Notice of Benefit and Payment Parameters*, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost-sharing plan variations.
Does this plan offer Composite Rating?	Select **No** for this field. This field is not applicable for PY2022.
Child-Only Offering*	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (a plan for individuals who have not attained the age of 21 for QHPs and 19 for SADPs at the beginning of the plan year); 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. Catastrophic plans must have a value of **Allows Adult and Child-Only** to validate. Choose from the following: ◆ **Allows Adult and Child-Only**—if the plan allows adult- and child-only enrollment and is offered at a child-only rate.

Plan Attributes	Steps
	◆ **Allows Adult-Only**—if the plan does <u>not</u> allow child-only enrollment. Children may enroll for this plan, but an adult must be the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Do not select this option for SADPs, which must be available to child-only subscribers. ◆ **Allows Child-Only**—if the plan is a child-only plan that allows only child subscribers. Do not select this option for catastrophic plans.
Child-Only Plan ID	Required if **Allows Adult-Only** is entered in *Child-Only Offering*. Enter the 14-character plan ID for the corresponding child-only plan if this plan does <u>not</u> allow child-only enrollment. The entered plan ID must correspond to a plan in which the Child-Only Offering is **Allows Adult and Child-Only** or **Allows Child-Only** and must have the same selection for *Level of Coverage* as the allows adult-only plan for which you are entering data.

Tobacco Wellness Program Offered	Indicate whether 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, as required to rate for tobacco use in the Small Group market. (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:
	◆ **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:
	  ▪ The plan is offered in the Individual market.
	  ▪ The plan is offered in the Small Group market and does not rate for tobacco use.

Disease Management Programs Offered#	Indicate whether the plan offers disease management programs. Choose one or more of the following: ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure and High Cholesterol ◆ Low Back Pain ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs.
EHB Percent of Total Premium	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). Note: This field is not applicable for SHOP market plans or catastrophic plans. The EHB Percent of Total Premium field should be the multiplicative inverse of the Unified Rate Review Template (URRT) field titled "Benefits in Addition to EHB" when rounded to the fourth decimal point (e.g., 1 divided by Benefits in Addition to EHB). As part of data integrity review, Centers for Medicare & Medicaid Services (CMS) will identify any mismatch between EHB percent of total premium and the multiplicative inverse of "Benefits in Addition to EHB" for a non-catastrophic individual market QHP, and prompt you to confirm that the submitted values for "EHB percent of total premium" from the Plans & Benefits Template and "Benefits in Addition to EHB" from the URRT are correct. Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia should not be considered EHB, even if the State EHB Benchmark plan covers such benefits.[1] A state may require a QHP to offer benefits in addition to the EHB, but the state is required to defray the cost of such state-required benefits to the enrollee or to the QHP issuer on behalf of

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[1] 45 Code of Federal Regulations (CFR) 156.115(d).

Plan Attributes	Steps
	the enrollee.[2] How an individual market QHP issuer should handle the portion of premium related to these services depends on whether the state makes these defrayal payments to the enrollee or to the issuer: In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer: ◆ The issuer **should not** factor the cost of the state-required benefit the state is defraying into the calculation for the "EHB Percent of Total Premium" field on the Plans and Benefits Template and **should not** factor the cost of the state-required benefit into the total premium from which the EHB percent of premium is calculated. ▪ The QHP issuer should also indicate in the Benefits Information field on the Plans and Benefits template that the QHP covers the state-required benefit in question as a non-EHB. To add a benefit not already listed on the Plans and Benefits Template, QHP issuers can click the Add Benefit button on the menu bar under the Plans & Benefits ribbon. QHP issuers should mark the benefit as Not EHB as the EHB Variance Reason. ▪ The QHP issuer will not experience a warning error or any problems that would prevent validation of the Plans and Benefits Template if the QHP issuer excludes coverage of the state-required benefit when calculating the EHB Percent of Total Premium, even though the QHP issuer should indicate that the state-required benefit is covered as a non-EHB under the Benefits Information. In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee: ◆ The QHP issuer **should not** include the cost of the state-required benefit the state is defraying in the EHB Percent of Total Premium on the Plans and Benefits Template. However, the QHP issuer **should** include the cost of the state-required benefit in the total premium from which the EHB Percent of Total Premium is calculated (therefore treating it as non-EHB for purposes of the total premium). ▪ The QHP issuer should also indicate in the Benefits Information field on the Plans and Benefits template that the QHP covers the state-required benefit in question as a non-EHB. ▪ To add a benefit not already listed on the Plans and Benefits Template, QHP issuers can click the Add Benefit button on the menu bar under the Plans & Benefits ribbon. QHP issuers should mark the benefit as Not EHB as the EHB Variance Reason. For plans that include coverage of abortion services for which public funding is prohibited (also known as non-Hyde abortion services)[3] offered in states where the benefits package of the EHB benchmark plan includes such abortion services you must handle the portion of the premium related to these services using one of the two methods described below: ◆ If the plan is a QHP offered on the FFE or a State-based Exchange (SBE), do not include the percentage of the premium associated with such abortion services in the EHB percentage (even if these services are in the EHB benchmark package). The EHB percentage is used to calculate subsidy amounts and subsidy payments may not be provided for costs associated with such abortion services. Therefore, costs associated with such abortion services must be excluded from the EHB proportion, and reflected accordingly in the adjustment for benefits in addition to EHB. ◆ If the plan is not a QHP offered in the FFE or in an SBE but is only offered off the Exchange, the percentage of the premium associated with abortion services for which public funding is prohibited may be included in the EHB percentage. For plans that include coverage of abortion services for which public funding is permitted and that is offered in states where the benefits package of the EHB benchmark plan includes such abortion services, the plan should include the percentage of premium associated with these services in the EHB percentage. For plans that include coverage of abortion services for which public funding is prohibited and that the plan is covering outside of the scope of the state's EHB benchmark package, reflect any such covered abortion services as benefits in addition to EHB.

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[2] 45 CFR 155.170.

[3] 45 CFR 156.280(d).

4.4 Stand-Alone Dental Only

The fields in this section apply to SADPs only (Figure 2D-5).

Figure 2D-5. SADP-Only Fields

Stand-Alone Dental Only	Steps
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 only to 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). All SADP issuers must submit the Stand-Alone Dental Plans—Description of EHB Allocation Form as a supporting document. Note: This field is no longer applicable for SHOP market plans.
Guaranteed vs. Estimated Rate*	This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. We calculate the rates a consumer sees using the Rates Table Template and the Business Rules Template. If you select **Guaranteed Rate**, you commit to charging only the premium shown to the consumer on the FFE website, which is calculated by taking into account the consumer's geographic location, age, and other permissible rating factors provided for in the Rates Table Template and Business Rules Template. If you select **Estimated Rate**, consumers must contact you to determine a final rate. Select whether this plan offers guaranteed or estimated rates. Choose from the following: ◆ **Guaranteed Rate**—if the plan offers a guaranteed rate. ◆ **Estimated Rate**—if the plan offers an estimated rate.

4.5 Plan Dates

The fields in this section are for each plan's plan effective date and plan expiration (Figure 2D-6). The FFE rating engine uses the rate effective dates in the Rates Table Template, not the Plans & Benefits Template.

Figure 2D-6. Plan Dates

Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2022 plan year—even for existing plans offered on-Exchange in 2021. Enter the effective date of the plan using the mm/dd/yyyy format. This must be 01/01/2022 for all plans that will be offered on the FFE and the Federally-facilitated Small Business Health Options Program (FF-SHOP).
Plan Expiration Date*	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (this must be 12/31/2022 for the Individual market). FF-SHOP plans are effective for a 12-month plan year, so the plan expiration date is 12 months after the plan effective date.

4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Only select **Yes** for these data elements if your plan offers the entire benefit package for the geographic unit. Select **No** 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: ◆ **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*	If you select **Yes** for *Out of Country Coverage*, you must 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: ◆ **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*	If you select **Yes** for *Out of Service Area Coverage* field, you must enter a short description of the care obtained outside the service area that the plan covers.
National Network*#	Indicate whether a national network is available. Choose from the following: ◆ **Yes**—if a national network is available. ◆ **No**—if a national network is <u>not</u> available.

4.7 Benefit Information

The Benefit Information section of the template indicates the scope of benefits your plan covers (Figure 2D-8).

Figure 2D-8. Benefit Information Section

Click **Refresh EHB Data** on the menu bar under the **Plans & Benefits** ribbon. If this benefits package has multi-state plans (MSPs) using an alternate benchmark, click **Yes** in the pop-up. If it does not, click **No**. The

2022 QHP Application Instructions

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 that is not listed on the template, click **Add Benefit** on the menu bar under the **Plans & Benefits** ribbon.

- Determine whether the benefit is listed in the drop-down menu; if it is, select it. If the benefit is not listed in the drop-down menu, click **Custom** and type in the new benefit name. New benefit names must be different from existing benefit names.

- A row for this benefit will appear below the last row in the Benefit Information section.

- If you add a benefit by mistake, you may do one of the following:

  - Select **Not Covered** under *Is this Benefit Covered?* (see 4.9 Out of Pocket Exceptions).

  - Click **Refresh EHB Data** on the menu bar under the **Plans & Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, and Out of Pocket Exceptions sections, including the benefit added by mistake.

- If you are adding a benefit that is not found in the state's benchmark and are not substituting it for an EHB found in the state's benchmark, select **Not EHB** as the EHB variance reason.

- If you are adding a benefit that is not found in the state's benchmark and are substituting it for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the EHB variance reason.

- If you are adding 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 5.6 EHB Variance Reason and EHB Designation.

- Do not add multiple benefits with the same name to a benefits package. If you offer multiple cost-sharing schemas for a given benefit based on multiple limits, choose the cost-sharing type that applies to the limits in the *Limit Quantity* and *Limit Unit* fields for each of the network types.

4.8 General Information

Use this section to provide information on each benefit in the benefits package, such as benefit coverage, benefit limits, applicable exclusions, and benefit explanations (Figure 2D-9).

Figure 2D-9. General Information Fields

General Information	Steps
EHB*	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. You cannot edit this field. Note: Carefully review the benefits covered by your applicable EHB benchmark plan as identified on our [Information on Essential Health Benefits (EHB) Benchmark Plans website](#). After reviewing the applicable EHB benchmark plan documents, you may need to update the Benefits Package worksheet to accurately reflect your coverage of EHB benchmark benefits. See the instructions for the EHB Variance Reason field for more information on updating the Benefits Package worksheet.
Is this Benefit Covered?*	This field is auto-populated with **Covered** for benefits identified in the template as EHBs. If you change this field to **Not Covered**, you must substitute another benefit in its place and provide the [EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification Form](#) to support the actuarial equivalence of the substitution (see the EHB Variance Reason field). 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: ◆ **Covered**—if this benefit is covered by the plan. A benefit is considered covered if you cover the cost of the benefit via 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 consumer is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service?*	If you selected **Covered** in the *Is this Benefit Covered?* field, complete this field. This field is auto-populated for EHBs. If you change this field for an EHB, you must provide an EHB variance reason and supporting documents. For benefits that are not EHBs, choose from the following: ◆ **Yes**—if this benefit has quantitative limits. ◆ **No**—if this benefit does <u>not</u> have quantitative limits. Note: Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, you 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 Benefits Package worksheet, you must provide a separate limit for those benefits.
Limit Quantity*#	If you selected **Yes** for *Quantitative Limit on Service?*, complete this field. This field is auto-populated for EHBs. If you change this data element, you must provide an EHB variance reason. For benefits that are not EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., to set a limit of two specialist visits per year, enter **2** here).
Limit Unit*#	If you selected **Yes** for *Quantitative Limit on Service?*, complete this field. This field is auto-populated for EHBs. If you change this data element, select the **Substantially Equal** EHB variance reason. Enter the unit used to restrict this benefit (e.g., to set a limit of two specialist visits per year, enter **Visits per year** here). Choose from the following: ◆ 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 ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions

General Information	Steps
	◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. Limit units that do not align with the list above (such as a limit of one hearing aid per ear every 48 months for subscribers up to age 18) will not auto-populate in the *Limit Unit* field, but will auto-populate in the *Benefit Explanation* field. Quantitative limits that span several types of services will not auto-populate. For instance, the benefit "Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services" will only appear in the *Benefit Explanation* field. Multiple limit units will not auto-populate. To implement multiple limits, complete the *Limit Quantity* and *Limit Unit* fields with the information that should be displayed on the Plan Compare function of the FFE website, then put all other quantitative limits in the *Benefit Explanation* field. For example, to enter the benefit "Outpatient Rehabilitative Services—90 days per year; two treatments per year," you should enter **90** in the Limit Quantity field, **Days per year** in the *Limit Unit* field, and **Two treatments per year** in the *Benefit Explanation* field. The message "Quantitative limit units apply, see EHB benchmark" may appear in the *Benefit Explanation* field for benefits that do not have quantitative limits in the Benefits and Limits section of the [Information on EHB Benchmark Plans page](#) on the CCIIO website. This message appears when benefits identified in the Other Benefits section of the EHB Benchmark Benefit Template have quantitative limits that do not apply to all services in the higher-level benefit category.
Exclusions*#	Enter any benefit-level exclusions. ◆ If you cover particular services or diagnoses only under some circumstances, list the specific exclusions. ◆ If you do <u>not</u> exclude services or diagnoses, leave this field blank.
Benefit Explanation*#	Enter any benefit explanations. ◆ You might explain 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*	If you have changed the *Is this Benefit Covered?*, *Limit Units*, or *Limit Quantity* fields, or if your state's benchmark has an unallowable limit or exclusion under the PPACA, complete this field. Select from the following EHB variance reasons if this benefit differs from the state's benchmark:
	◆ **Not EHB**—if this benefit is <u>not</u> an EHB.
	   ▪ If you have added a new benefit not found in the state's benchmark, the *EHB* field will be blank and you should set the EHB variance reason to **Not EHB**. This benefit is <u>not</u> considered an EHB.
	   ▪ If a benefit auto-populated as **Yes** in the EHB column, but we or your state have directed you that the benefit should not be considered an EHB, set the EHB variance reason to **Not EHB**. This benefit is <u>not</u> considered an EHB.
	◆ **Substituted**—if a benefit is included in your state's EHB benchmark, the *EHB* field auto-populates as **Yes**. If you substitute a different benefit for an EHB, set the *EHB Variance Reason* to **Substituted** and *Is this Benefit Covered?* to **Not Covered**. The benefit you substitute must be designated as an **Additional EHB Benefit**.
	◆ **Substantially Equal**—if the limit quantity or limit unit for a benefit differs from the limit quantity or limit unit in the EHB benchmark but is substantially equal to the EHB benchmark, select **Substantially Equal** as the variance reason. For example, a benchmark limit of 40 hours per month is substantially equal to a plan limit of 5 days per month where a day is defined as 8 hours.
	◆ **Using Alternate Benchmark**—Select this EHB variance reason for any benefit that has auto-populated **Yes** in the *EHB* column, but is not an EHB in the alternate benchmark.

2022 QHP Application Instructions

General Information	Steps
	◆ **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 is not represented in the state's EHB benchmark plan, set *Is this Benefit Covered?* to **Covered** and set the variance reason to **Other Law/Regulation**. (State-required benefits that were enacted after December 31, 2011, are <u>not</u> EHBs. Use **Not EHB** as the variance reason for such benefits.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan and the state requires coverage only in the Individual market. ◆ **Additional EHB Benefit**—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list, change the benefit to **Covered,** and choose **Additional EHB Benefit** as the EHB variance reason. For example, covered non-preferred brand drug benefits may not appear to be covered in the auto-populated table. 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 you are only covering the dental EHB using a separate dental-only plan, set the EHB variance reason to **Dental Only Plan Available**. For example, if you offer SADPs to cover pediatric dental benefits, you do not need to cover pediatric dental in QHPs. Select **Not Covered** and **Dental Only Plan Available** as the EHB variance reason for benefits such as Dental Check-Up for Children, Basic Dental Care—Child, Orthodontia—Child, and Major Dental Care—Child if the benefits are designated as a **Covered** EHB. (This option is not applicable to SADPs.) Note: EHB benchmark plan benefits are based on plans that were sold previously and may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, you may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Carefully review the information available on the Information on EHB Benchmark Plans page on the CCIIO website. If more than one EHB variance reason applies, select the variance reason related to EHB designation instead of the one related to limits because the EHB variance reason affects non-discrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to CSR plan variations. For example, if an issuer adds a new benefit that is an EHB and changes its limits, select **Additional EHB Benefit** variance reason instead of **Substantially Equal**.

4.9 Out of Pocket Exceptions

This section allows you to indicate 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, you must create a new benefits package and complete a new Cost Share Variances worksheet (Figure 2D-10).

Figure 2D-10. Out of Pocket Exceptions

Out of Pocket Exceptions	Steps
Excluded from In Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits that are not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following: ◆ **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*	Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following: ◆ **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.

Out of Pocket Exceptions	Steps
◆ If the plans only have a combined (no separate in-network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP*. ◆ If *Is this Benefit Covered?* is **Not Covered** or blank, leave the *Excluded from In Network MOOP* and *Excluded from Out of Network MOOP* fields blank. ◆ If the plans do not have an out-of-network MOOP, set *Excluded from Out of Network MOOP* equal to **Yes**.	

After the above benefit-related information is entered in the Benefits Package worksheet, click **Create Cost Share Variances** on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-11). The Cost Share Variances worksheet collects detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2D-11. Create Cost Share Variances Button
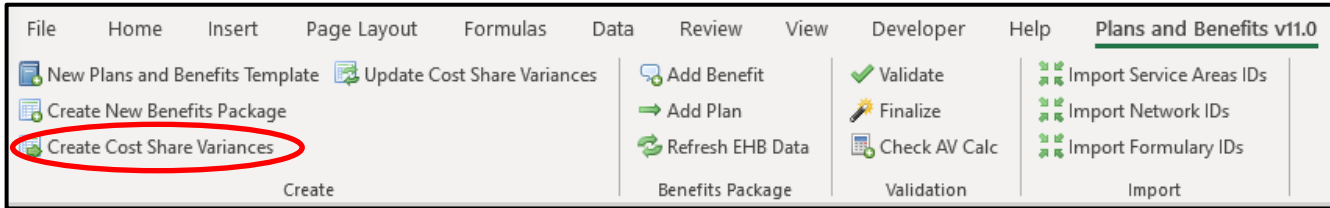
Click **OK** after reading the warnings (Figure 2D-12) and make any necessary changes.

Figure 2D-12. Warning Pop-Up Boxes
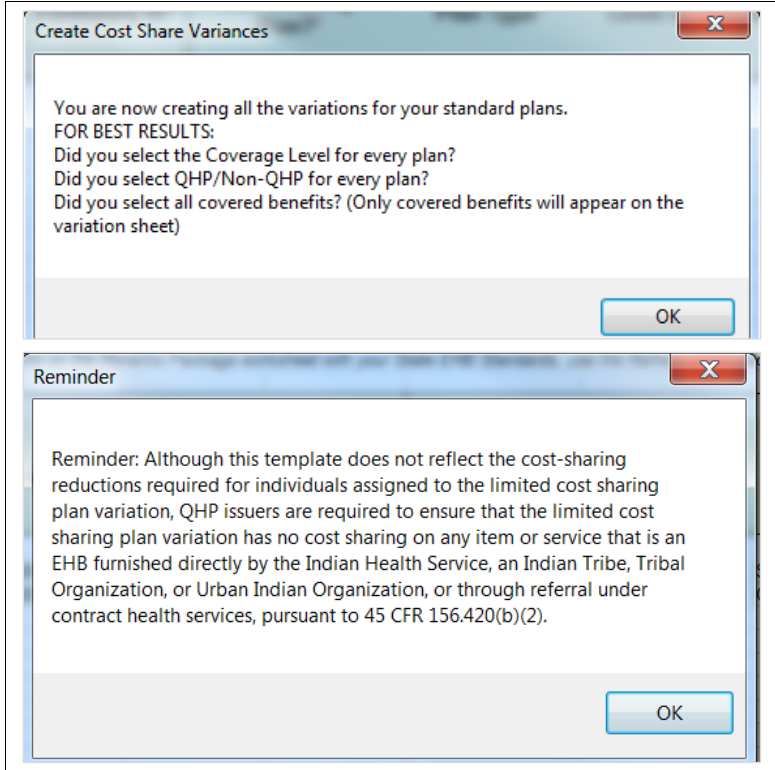
After you address the warnings, the following series of questions regarding deductible sub-groups appears (Figure 2D-13). Use deductible sub-groups to identify benefits or groupings of benefits that have separate deductibles. Deductible sub-groups are not separate from the maximums allowed, and they still contribute to the overall MOOP and deductible limits. You are not required to use deductible sub-groups.

Figure 2D-13. Deductible Sub-Groups
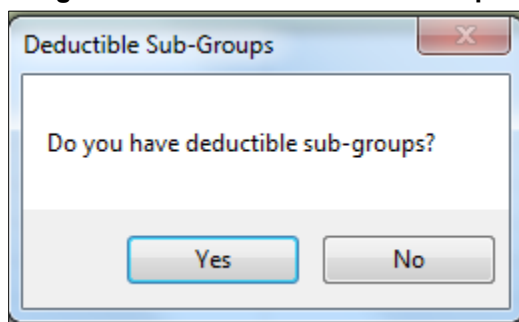
1. Do you have any deductible sub-groups?

    a. **Yes**—if the plan contains deductible sub-groups.

    b. **No**—if the plan does not contain deductible sub-groups.

2. If you select **Yes** for the previous question, the following questions will appear:

    a. How many deductible sub-groups do you have?

        i. Enter the correct number and click **OK**.

    b. What is the name of this deductible sub-group?

        i. Enter a sub-group name and click **OK**. Repeat for each of your deductible sub-groups. You must use a different name for each sub-group.

A new Cost Share Variances worksheet is created for each Benefits Package worksheet (Figure 2D-14). Verify that any auto-populated information is accurate, then enter information for each benefits package in the corresponding Cost Share Variance worksheet, which will be labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2.

Figure 2D-14. Cost Share Variances Worksheet

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

4.10 Plan Cost-Sharing Attributes

This section collects basic information for each plan and CSR 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 you submit, but CSRs do not apply to SADPs.

2022 QHP Application Instructions

Plan Cost-Sharing Attributes	Steps

HIOS Plan ID*	The HIOS-generated number auto-populates for each cost-sharing plan variation.
	◆ Standard plans to be offered on the Exchange have a plan ID variant suffix of "−01," and standard plans to be offered off the Exchange have a plan ID variant suffix of "−00."
	◆ For the Individual market, each standard plan (except for catastrophic) has two CSR plan variations for American Indians and Alaska Natives: one with zero cost sharing (plan ID variant suffix "−02") and one with limited cost sharing (plan ID variant suffix "−03").
	  ▪ In the zero cost-sharing plan variation, consumers do not 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 another provider with a referral from an Indian health care provider.
	◆ In the Individual market, each silver plan has three additional CSR plan variations: a 73 percent AV plan (plan ID variant suffix "−04"), an 87 percent AV plan (plan ID variant suffix "−05"), and a 94 percent AV plan (plan ID variant suffix "−06").
	  ▪ These silver plan variations lower the MOOP and the amounts consumers pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers qualify for these plans if their income is below a certain level.

Plan Variant Marketing Name*#	The name of the plan auto-populates the standard plan's marketing name for all standard plans and plan variations. The name entered in this field will display to consumers, so enter the name for each of your plan variations in this field. The field has a limit of 255 characters.
Level of Coverage^*	The coverage level for the plan auto-populates for standard plans.
CSR Variation Type^	The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, as a standard off-Exchange plan, or as one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	If you entered **Yes** for *Unique Plan Design* in the Benefits Package worksheet, enter the AV. This applies to health plans that indicate they are a unique plan for AV purposes. Note: SADP issuers are not required to enter a value for this field for the template to validate. Instead, submit the [Stand-Alone Dental Plan Actuarial Value Supporting Documentation Form](). If you choose to provide your plan's AV in this field, you must enter either a **High** or **Low** value to ensure template validation, which requires a value to fall within either one of these ranges, regardless of which of the two values is entered: **Low**—AV of 70 percent **High**—AV of 85 percent.
AVC Output Number	After completing the cost-sharing information and benefits package information, click **Check AV Calc** on the Plans & Benefits ribbon and select the correct file to populate this field with the AV for all plans on this worksheet using non-unique plan designs. For more information, see Appendix A. This field is required for QHPs but optional for SADPs.
Medical & Drug Deductibles Integrated?^	Indicate whether your medical and drug deductibles are integrated. An integrated deductible allows both medical and drug charges to contribute to a total plan-level deductible. Separate deductibles indicate medical and drug charges contribute to separate plan-level deductibles. Choose from the following: ◆ **Yes**—if the medical and drug deductibles are integrated. If you enter **Yes**, do not enter information in the Medical Deductible section (4.16) or the Drug Benefits Deductible section (4.17). ◆ **No**—if the medical and drug deductibles are not integrated. If you enter **No**, do not enter information in the Combined Medical & Drug Deductible section (4.18).

Plan Cost-Sharing Attributes	Steps
Medical & Drug Maximum Out of Pocket Integrated?^	Indicate whether the medical and drug MOOPs are integrated. An integrated MOOP allows medical and drug charges to contribute to a total plan-level MOOP. Separate MOOPs indicate medical and drug charges contribute to separate plan-level MOOP values. Choose from the following: ◆ **Yes**—if the medical and drug MOOPs are integrated. If you enter **Yes**, do not enter information in the Maximum Out of Pocket for EHB Benefits section (4.13) or the Maximum Out of Pocket for Drug Benefits section (4.14). ◆ **No**—if the medical and drug MOOPs are <u>not</u> integrated. If **No** is entered, issuers should not enter information in the Maximum Out of Pocket for EHB and Drug Benefits (Total) section (4.15).
Multiple In Network Tiers?^*	Indicate whether there are multiple in-network provider tiers that allow the plan to apply different levels of in-network cost sharing depending on the provider or facility tier. The value must be the same for all variations of a plan. Choose from the following: ◆ **Yes**—if there are multiple in-network provider tiers. Enter Tier 1 information into the *In Network* and *In Network (Tier 1)* sections and Tier 2 information into the *In Network (Tier 2)* sections. ◆ **No**—if there are <u>not</u> multiple in-network provider tiers. If you select this response, you will not be able to enter information in the *In Network (Tier 2)* sections, which will be grayed out and locked.
1st Tier Utilization^*	If you respond **Yes** to *Multiple In Network Tiers?*, enter the 1st Tier Utilization as a percentage here. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. The field auto-populates to 100% if you respond **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 1st Tier Utilization.)
2nd Tier Utilization^*	If you respond **Yes** to *Multiple In Network Tiers?*, enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked if you respond **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 2nd Tier Utilization.)

4.11 Summary of Benefits and Coverage Scenario

You will complete three Summary of Benefits and Coverage (SBC) scenarios in this section. Additional information on SBC scenarios and further resources for completing the scenarios can be found on the Summary of Benefits and Coverage and Uniform Glossary page of the CCIIO website. Direct any concerns or requests for technical assistance to sbc@cms.hhs.gov. Complete the following data fields for all three coverage examples (Having a Baby, Having Diabetes, and Treatment of a Simple Fracture). This section is not applicable to SADPs.

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.

4.12 Maximum Out of Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Complete sections 4.13 and 4.14 only if you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; complete section 4.15 only if you responded **Yes**. Complete sections 4.16 and 4.17 only if you responded **No** to *Medical & Drug Deductibles Integrated?*; complete section 4.18 only if you responded **Yes**. If you only issue SADPs, skip to sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (5.1 MOOP and Deductible Guidance provides guidance on completing and meeting all requirements in the MOOP and deductible sections of the template.)

The *Family* fields for the *In Network*, *In Network (Tier 2)*, and *Out of Network* MOOP and deductible values will have additional options. When selecting these fields, a dialogue box 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 display 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 field:

- The per-person amount for family coverage must be less than or equal to the proposed individual MOOP limit for the standard plan ($9,100) and for the specific CSR plan variations.[4] See 5.5 Requirements for CSR Plan Variations for details about the proposed individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.

- You must enter a per-person amount and per-group amount for MOOP; you may not enter **Not Applicable** for all these cells in all *Family* fields unless a plan is available to consumers only as self-only coverage.

4.13 Maximum Out of Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in Figure 2D-15.

Figure 2D-15. MOOP Fields

Use this section to input MOOP values for medical EHBs only if your medical and drug MOOPs are <u>not</u> integrated (i.e., you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for EHBs in the following areas of the template.

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

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[4] The final values in this section are subject to change upon finalization of the remaining policies in the proposed *2022 Payment Notice*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2022*.

4.14 Maximum Out of Pocket for Drug EHB Benefits

Use this section to input MOOP values for drug EHBs only if your medical and drug MOOPs are not integrated (i.e., you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for drug EHBs in the following areas of the template.

MOOP Drug EHB Benefits	Steps
In Network—Individual^#	If the MOOPs are not integrated, enter the dollar amount for *In Network Individual Maximum Out of Pocket for Drug EHB Benefits*.
In Network—Family#	If the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Maximum Out of Pocket for Drug EHB Benefits*.
In Network (Tier 2)—Individual^	If the 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* 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 amounts 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
Out of Network—Individual	If the 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 the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.
Combined In/Out Network—Individual^#	If the 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 the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.

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

Use this section to input MOOP values for medical and drug EHBs only if your medical and drug MOOPs are integrated (i.e., you responded **Yes** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **No**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for medical and drug EHBs in the following areas on the template.

MOOP Medical and Drug EHB Benefits	Steps
In Network—Individual^#	If the MOOPs are integrated, enter the dollar amount for the *Total In Network Individual Maximum Out of Pocket*.
In Network—Family#	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total In Network Family Maximum Out of Pocket*.
In Network (Tier 2)—Individual^	If the 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.
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 amounts 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.

MOOP Medical and Drug EHB Benefits	Steps
Out of Network—Individual	If the MOOPs are integrated, enter the dollar amount for the *Total Out of Network Individual Maximum Out of Pocket*.
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total Out of Network Family Maximum Out of Pocket*.
Combined In/Out Network—Individual^#	If the 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 the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total Combined In/Out of Network Family Maximum Out of Pocket*.

4.16 Medical EHB Deductible

Use this section to input deductible values for medical EHBs only if your medical and drug deductibles are not integrated (i.e., you responded **No** to *Medical & Drug Deductibles Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for EHBs in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *In Network Individual Medical EHB Deductible*.
In Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Medical EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are not integrated, you must complete this field for the AV calculation if your plan uses the AVC.
In Network (Tier 2)—Individual^	If the 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.
In Network (Tier 2)—Family	If the deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts 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.
In Network (Tier 2)—Default Coinsurance^	If the 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.
Out of Network—Individual	If the deductibles are not integrated, enter the dollar amount for *Out of Network Individual Medical Deductible*.
Out of Network—Family	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Medical EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *Combined In/Out of Network Individual Medical EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Medical EHB Deductible*.

4.17 Drug EHB Deductible

Use this section to input deductible values for drug EHBs only if the medical and drug deductibles are not integrated (i.e., you responded **No** to *Medical & Drug Deductibles Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for drug EHBs in the following areas on the template.

Drug EHB Deductible	Steps
In Network—Individual^#	If the deductibles are <u>not</u> integrated, enter the dollar amount for *In Network Individual Drug EHB Deductible*.
In Network—Family#	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for *In Network Family Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are <u>not</u> integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual^	If the deductibles are <u>not</u> 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* field.)
In Network (Tier 2)—Family	If the deductibles are <u>not</u> 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
In Network (Tier 2)—Default Coinsurance^	If the deductibles are <u>not</u> 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Default Coinsurance* field.)
Out of Network—Individual	If the deductibles are <u>not</u> integrated, enter the dollar amount for *Out of Network Individual Drug EHB Deductible*.
Out of Network—Family	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Drug EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are <u>not</u> integrated, enter the dollar amount for *Combined In/Out of Network Individual Drug EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Drug EHB Deductible*.

4.18 Combined Medical and Drug EHB Deductible

Use this section to input deductible values for medical and drug EHBs only if the medical and drug deductibles are integrated (i.e., you responded **Yes** to *Medical & Drug Deductibles Integrated?*; if you responded **No**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for medical and drug EHBs in the following areas on the template.

Medical and Drug EHB Deductible	Steps
In Network—Individual^#	If the deductibles are integrated, enter the dollar amount for *In Network Individual Combined Medical and Drug EHB Deductible*.
In Network—Family#	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *In Network Family Combined Medical and Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are integrated, you must complete this field for the AV calculation if your plan uses the AVC.
In Network (Tier 2)—Individual^	If the 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.
In Network (Tier 2)—Family	If the deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for *In Network (Tier 2) Family Combined Medical*

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

4.19 Maximum Out of Pocket for Dental EHB Benefits

Use this section to input MOOP values for dental EHBs. When entering the MOOP values, ensure that the MOOP values are equal to or below the required limits of $350 for one covered child and $700 for two or more covered children. 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 MOOPs for dental EHBs in the following areas of the template.

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

4.20 Dental EHB Deductible

Use this section to input deductible values for dental EHBs. 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 deductibles for EHBs in the following areas on the template.

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

4.21 Other Deductible

Complete this section if you have deductible sub-groups; you 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 contribute to the MOOP and deductible limits.)

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

4.22 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: ◆ **Yes**—if the plan meets all HSA requirements. ◆ **No**—if the plan does not meet all HSA requirements. Note that you should select **No** for zero cost sharing plan variations and limited cost sharing plan variations because they do not meet the requirements to be HSA-eligible. Failure to enter the correct response will result in a Data Integrity review error.
HSA/HRA Employer Contribution^	If you are offering a small group plan, indicate whether the employer contributes to an HSA/HRA. Leave this field blank for the Individual market. Choose from the following: ◆ **Yes**—if the plan has an HSA/HRA employer contribution. ◆ **No**—if the plan does not have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount^	If you responded **Yes** to *HSA/HRA Employer Contribution* enter a numerical value representing the employer contribution amount to the HSA/HRA. Leave this field blank for Individual market plans; the template does not permit an Individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 *Federal Register* 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.

4.23 AVC Additional Benefit Design

This section contains optional fields, which you may fill out to use as inputs in the AVC.

AVC Additional Benefit Design	Steps
Maximum Coinsurance for Specialty Drugs^	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?^	Enter the maximum number of days a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost Sharing After a Set Number of Visits?^	Enter the maximum number of fully covered visits before primary care cost sharing begins (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?^	Enter the maximum number of copay primary care visits that can occur before visits become subject to the deductible and/or coinsurance (1–10). If this option does not apply, leave the field blank.

4.24 Covered Benefits

Use this section to enter copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

1. If you offer plans that do cover a given benefit out of network, enter **Not Applicable** for the out-of-network copay fields and **100%** for the out-of-network coinsurance fields.

2. Use the **Not Applicable** drop-down menu option in the following scenarios:

    a. If you charge only a copay or a coinsurance for a benefit, enter **Not Applicable** for the one you do not charge. For example, if you charge a $20 copay for a benefit, enter **$20** for the copay and **Not**

Applicable for the coinsurance. Note: **No Charge** was used for this scenario in past years, but **Not Applicable** is the correct option in the 2022 template.

    b. If you have multiple in-network tiers, enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance for all benefit categories that do not have tiers. For example, if you have multiple in-network tiers only for your inpatient hospital covered benefits, you should enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance.

3. For further instructions on coordinating the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see 5.8 Suggested Coordination of Drug Data between Templates.

4. For further instructions on filling out the copayment and coinsurance fields corresponding to the AVC, please see Appendix A.

5. See 5.5 Requirements for CSR Plan Variations for cost-sharing requirements for the CSR silver plan variations and the zero and limited cost-sharing plan variations.

6. If cost sharing varies based on place of service or provider type and no benefit specifically applies to the place of service or provider type, fill out the copay and coinsurance you will most commonly charge. Briefly detail less common cost-sharing exceptions in the *Benefit Explanation* field. Clearly communicate any cost-sharing information that varies based on the place of service or provider type in the plan brochure.

Figure 2D-16 shows an example of how the fields for each benefit are laid out.

Figure 2D-16. Benefit Information Fields

BV	BW	BX	BY	BZ	CA
		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
	$0	$0	$0	0%	0%	0%

Covered Benefits	Steps
Copay—In Network (Tier 1)*^#	If you charge an in-network copayment, enter the dollar amount in this field. If no copayment is charged, enter **Not Applicable**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for copayment if a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer first meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ **$X Copay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—after the consumer pays the copay, 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 <u>not</u> 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)*^#	If a plan has multiple in-network tiers and you charge an in-network copayment, enter the dollar amount in this field. If you do not charge a copayment, enter **Not Applicable**. For any benefit category that does not have tiers, enter **Not Applicable** for this field and

Covered Benefits	Steps
	Coinsurance—In Network (Tier 2). This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for copay if only a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ **$X Copay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance, <u>or</u> this benefit does not have multiple tiers. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—Out of Network*#	If you charge an out-of-network copayment, enter the amount in this field. If you do not charge a copayment, enter **Not Applicable**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for copayment if only a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ **$X Copay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—after the consumer pays the copay, 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 <u>not</u> 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	The following are only available for Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility benefits. 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**. The benefits Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services include these options as well as those described in *Copay—In Network (Tier 1)* above. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for copayment if only a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copay 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). ◆ **$X Copay per Day after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible).

Covered Benefits	Steps
	◆ **$X Copay per Stay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible).
	◆ **$X Copay per Day with deductible**—after the consumer pays the copay per day, 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**—after the consumer pays the copay per stay, 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 <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
	For Inpatient Hospital Services and Skilled Nursing Facility covered benefits, <u>do not</u> copy and paste cost-sharing values entered for other benefits (e.g., $25 copay). Instead, enter values with 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.
Coinsurance—In Network (Tier 1)*^#	If you charge an in-network coinsurance, enter the percentage the consumer will pay in this field. If you do not charge a coinsurance, 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:
	◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged.
	◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible).
	◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).
	◆ **X%**—the consumer pays just the coinsurance and you pay 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 <u>not</u> 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)*^#	If a plan has multiple in-network tiers and you charge an in-network coinsurance, enter the percentage the consumer will pay in this field. If you do not charge a coinsurance, 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** in this field and in the *Copay—In Network (Tier 2)* field. This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following:
	◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged.
	◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible).
	◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).
	◆ **X%**—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible).

Covered Benefits	Steps
	◆ **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 <u>not</u> 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*#	If you charge an out-of-network coinsurance, enter the percentage the consumer pays here. If you do not charge a coinsurance, 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 you do not cover this benefit out of network, enter **100%**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer pays just the coinsurance, and you pay 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 <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.25 Completed Plans & Benefits Template

After entering all data, including all Benefits Package and Cost Share Variances worksheets, click **Save** to ensure no data are lost. Once the Plans & Benefits Template is completed, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** on the menu bar under the **Plans & Benefits** ribbon. 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 reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** on the menu bar under the **Plans & Benefits** ribbon to create the .XML version of the template you will upload in the Plans & Benefits section of the Benefits and Service Area Module in HIOS.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Plans & Benefits section of the Benefits and Service Area Module in HIOS. Refer to 2. Benefits and Service Area Module for details on how to complete this step.

Figure 2D-17. Validate and Finalize Buttons

2022 QHP Application Instructions
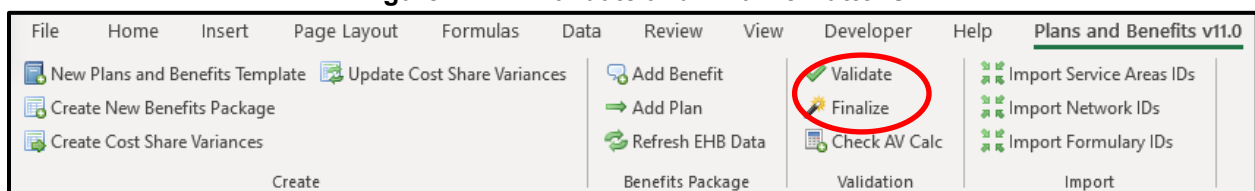
5. Key Requirements and Application Guidance

This section contains guidance and examples for filling out specific sections of the Plans & Benefits Template and describes specific plan requirements. Read this section to ensure your plans comply with all requirements.

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. See the proposed rule Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2022 and Pharmacy Benefit Manager Standards; Updates To State Innovation Waiver (Section 1332 Waiver) Implementing Regulations (proposed *2022 Payment Notice*) for more details on the proposed annual limitation on cost sharing values.[5] Ensure that the following limits are met for the in-network EHB MOOP:

   a. If a 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 the proposed MOOP of $9,100 for an individual (self-only) or the proposed MOOP of $18,200 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 the proposed MOOP of $7,250 for an individual (self-only) or the proposed MOOP of $14,500 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 the proposed MOOP of $3,000 for an individual (self-only) or the proposed MOOP of $6,000 for a family (other than self-only).

   e. For the zero cost-sharing plan variations, the in- and out-of-network MOOP and deductible values for EHBs must be $0. These fields will auto-populate and should not be changed for EHBs.

   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 will auto-populate with the values entered for a standard plan and should not be changed.

2. Family MOOP Requirements.[6] Ensure that the following limits are taken into consideration:

   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 (the proposed MOOP of $18,200) 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 (the proposed MOOP of $9,100) and for the specific CSR plan variations as detailed in Annual Limitation on Cost Sharing above.[7]

   c. For plans that allow only self-only coverage (individual plans), 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 Section 3B: Business Rules for more details on offering self-only coverage and eligible dependent relationships.)

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[5] The final values in this section are subject to change upon finalization of the remaining policies in the proposed *2022 Payment Notice*.

[6] See the *2022 Payment Notice*.

[7] See the *2022 Payment Notice*. You must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2022*.

3. Definition of **Not Applicable** and **$0** for deductibles and MOOPs.

    a. Enter **$0** <u>not</u> **Not Applicable** if there is a zero-dollar deductible or MOOP. For example, if a plan has separate medical and drug deductibles, but there is no drug deductible, you must enter **$0**.

    b. **Not Applicable** should be used in the *In Network* MOOP or deductible fields only to imply that in-network service costs accumulate toward the *Combined In/Out of Network* MOOP or deductible.

    c. If you enter **Not Applicable** in *Individual In Network* and *Individual Combined In/Out of Network*, the template will return an error when calculating the plan's AV using the AVC.

4. Use the *Family* MOOP and deductible fields to include multiple children in child-only plans.

5. The following explains how the values for various MOOP and deductible fields are related:

    a. Plans may have a combined deductible and combined MOOP, separate deductibles and separate MOOPs, or both (deductibles combined, MOOPS separate OR deductibles separate and MOOPs combined) for both in-network and out-of-network charges. When defining deductibles and MOOPs, ensure your plan adheres to the guidelines.

    b. If the plan does <u>not</u> have multiple in-network tiers, the following apply:

        i. If *In Network* is equal to a dollar value ($X), *Combined In/Out of Network* can be either a dollar value or **Not Applicable**.

        ii. If *In Network* is **Not Applicable**, *Combined In/Out of Network* must contain a dollar value.

        iii. *Out of Network* has no restrictions; it can be either a dollar value or **Not Applicable**.

    c. If the plan <u>has</u> multiple in-network tiers, the following apply:

        i. If *In Network* and *In Network (Tier 2)* are equal to dollar values, *Combined In/Out of Network* can be either a dollar value or **Not Applicable**.

        ii. If *In Network* is **Not Applicable**, *In Network (Tier 2)* must be **Not Applicable** and *Combined In/Out of Network* must contain a dollar value.

        iii. If *In Network (Tier 2)* is **Not Applicable**, *In Network* must be **Not Applicable** and *Combined In/Out of Network* must contain a dollar value.

        iv. *Out of Network* 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 PPACA 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 multi-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 PPACA and in the proposed *2022 Payment Notice*. For PY2022, the proposed limit is $9,100 for individuals (self-only) and $18,200 for families (other than self-only).[8]

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[8] Final values are subject to change upon finalization of the remaining policies in the proposed *2022 Payment Notice*.

7. They have an out-of-network deductible and an out-of-network MOOP greater than or equal to the annual limitation on cost sharing or that are identified as **Not Applicable**.

8. If they have an in-network deductible and in-network MOOP and a combined in- and 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 identified as **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 deductible** for all EHBs, excluding primary care and preventive health services. (See 5.10 Plan Compare Cost-Sharing Display Rules for direction on completing the copay and coinsurance fields for how cost-sharing information is displayed to the consumer on Plan Compare.)

11. All benefits except primary care visits and coverage of preventive health services are subject to the in-network deductible and you must provide benefits for at least three primary care visits and cover preventive health services before the customer reaches the deductible, in accordance with Section 2713 of the PHS Act.

12. Coverage of preventive health services is not subject to the in-network deductible and does not impose any other cost-sharing requirement, in accordance with Section 2713 of the PHS Act.

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 −4/+2 percentage points is used for standard plans.

    a. The AV for a bronze plan must be between 56 percent and 62 percent.

    b. The AV for an expanded bronze plan must be between 56 percent and 65 percent.

    c. The AV for a silver plan must be between 66 percent and 72 percent.

    d. The AV for a gold plan must be between 76 percent and 82 percent.

    e. The AV for a platinum plan must be between 86 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 A.)

5.4 Editing the Template

Keep the following in mind when changing the template:

1. If you add a benefit as an additional benefit by mistake, you may do one of the following to remove it:

    a. Select **Not Covered** under *Is this Benefit Covered?* When the Cost Share Variances worksheet is generated, this benefit will not appear on that worksheet.

b. Click **Refresh EHB Data** on the menu bar under the **Plans & Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, Deductible, and Out of Pocket Exceptions sections, including the benefit added by mistake.

2. If you wish to remove an additional benefit or change whether it is **Covered** on the Benefits Package worksheet after you create the Cost Share Variances worksheet, you must delete the entire Cost Share Variances worksheet and generate a new one by clicking **Create Cost Share Variances** on the menu bar under the **Plans & Benefits** ribbon.

3. To add or remove plans after creating the Cost Share Variances worksheet, do the following:

   a. Add the new plan to the Benefits Package worksheet, then click **Update Cost Share Variances** 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, then copy and paste the data for any plans beneath that row up to fill the empty row (as shown in Figure 2D-18) and click **Update Cost Share Variances**. For example, to delete Plan 2, you would delete all data from row 10, cut and paste Plan 3 into row 10 and Plan 4 into row 11, then click **Update Cost Share Variances** to remove Plan 2 from the Cost Share Variances worksheet, but leave Plan 3 and Plan 4. Any plans below an empty row and their corresponding data will be deleted from the Cost Share Variances worksheet if you click **Update Cost Share Variances** when there is an empty row between plans.

Figure 2D-18. Deleting a Plan

   c. If you change any benefits package data for an existing plan, only the following changes will be reflected on the Cost Share Variances worksheet when you click **Update Cost Share Variances**:

      i. Plan Marketing Names will be updated.

      ii. Plans added to the Benefits Package worksheet will be added to the Cost Share Variances worksheet.

      iii. Plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet.

   d. To update the information for an existing plan, do the following:

      i. Delete that plan on the Benefits Package worksheet, as explained above, and then click **Update Cost Share Variances** to delete it from the Cost Share Variances worksheet.

      ii. Reenter the plan and associated data on the Benefits Package worksheet, and click **Update Cost Share Variances** to add the plan back to the Cost Share Variances worksheet.

5.5 Requirements for CSR Plan Variations

There are three types of CSR plan variations: 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 with a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the MOOP and the amount consumers pay out-of-pocket for deductibles, coinsurance, and copayments. Consumers qualify to enroll in 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 zero cost-sharing plan variation is not required to cover out-of-network services either. (See 5.6 EHB Variance Reason and EHB Designation 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 5.7 Successive Cost Sharing Guidance 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 EHBs must be the same as the associated standard plan's MOOP values for EHBs.

   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 5.6 EHB Variance Reason and EHB Designation).

   f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see 5.7 Successive Cost Sharing Guidance).

   g. Tier utilization must be the same as the associated standard plan's tier utilization.

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.

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

b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and must 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 $7,250 for an individual (self-only) or $14,500 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 $3,000 for an individual (self-only) or $6,000 for a family (other than self-only).

g. All MOOP values must follow successive cost sharing for all plan variations (see 5.7 Successive Cost Sharing Guidance).

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's tier utilization.

5.6 EHB Variance Reason and EHB Designation

As explained in 5.5 Requirements for CSR Plan Variations, 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 responses in *EHB* and *EHB Variance Reason* on the Benefits Package worksheet as outlined in 4.9 Out of Pocket Exceptions. Table 2D-1 explains when a benefit is considered an EHB based on different inputs.

Table 2D-1. EHB Designation

EHB Field Value	EHB Variance Reason Field Value	Evaluated as an EHB?
Yes	Anything other than **Not EHB**	Yes
Blank	**Additional EHB Benefit** or **Other Law/Regulation**	Yes
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 5.5 Requirements for CSR Plan Variations, successive cost sharing is required to offer multiple plan variations and data fields. Successive cost sharing ensures that parts of a given plan variation always offer equal or more generous cost-sharing value for the consumer than a standard plan or plan variation.

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. 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. 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. 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.

MOOP, deductible, copay, and coinsurance may be used for successive cost sharing. Because successive cost sharing requires that the plan <u>always</u> be equal or preferable to the consumer, you may not change the cost-sharing structures such that the consumer in the higher AV plan variation may pay increased cost sharing in any circumstance. These 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 cost of the service determines which is the better value.

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 if the deductible has not been reached.

Tables 2D-2 through 2D-8 show compliant and noncompliant data entry options for cost-sharing fields, 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% ≤ 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% ≤ X%) ◆ Y% Coinsurance After Deductible (when Y% ≤ 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%	

Plan	Coinsurance	Compliance
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 Options 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	◆ No Charge ◆ $0 Copay ◆ Not Applicable	◆ 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	◆ No Charge ◆ No Charge After Deductible ◆ $0 Copay ◆ $0 Copay After Deductible ◆ Not Applicable	◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (when greater than 0) ◆ $Y Copay With Deductible (all values)
$X Copay	◆ No Charge ◆ $Y Copay (when $Y \leq $X) ◆ Not Applicable	◆ No Charge After Deductible ◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ $Y Copay (when $Y \leq $X) ◆ $Y Copay After Deductible (when $Y \leq $X) ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (when $Y > $X) ◆ $Y Copay With Deductible (all values)
$X Copay With Deductible	◆ No Charge ◆ $Y Copay (when $Y < $X) ◆ $Y Copay With Deductible (when $Y \leq $X) ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (when $Y > $X)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ 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	◆ $Y Copay Per Day (when $Y ≤ $X) ◆ $Y Copay Per Stay (when $Y ≤ $X) ◆ No Charge ◆ Not Applicable	◆ $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	◆ $Y Copay Per Stay (when $Y ≤ $X) ◆ $0 Copay Per Day ◆ No Charge ◆ Not Applicable	◆ $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	◆ $Y Copay Per Day With Deductible (when $Y < $X) ◆ $Y Copay Per Stay With Deductible (when $Y < $X) ◆ No Charge ◆ No Charge After Deductible ◆ $Y Copay per Day (when $Y < $X) ◆ $Y Copay per Stay (when $Y < $X) ◆ Not Applicable	◆ $Y Copay Per Day With Deductible (when $Y > $X) ◆ $Y Copay Per Day (when $Y > $X) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Stay With Deductible (when $Y > $X) ◆ $Y Copay Per Stay After Deductible (all values) ◆ $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 With Deductible	◆ $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	◆ $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	◆ $Y Copay Per Day After Deductible ($Y < $X) ◆ $Y Copay Per Stay After Deductible ($Y < $X) ◆ $Y Copay Per Day ($Y < $X) ◆ $Y Copay Per Stay ($Y < $X)	◆ $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)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
	◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable	◆ $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	◆ $Y Copay Per Stay After Deductible ($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	◆ $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	◆ 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	◆ $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)
No Charge	◆ No Charge ◆ $0 Per Day ◆ $0 Per Stay ◆ Not Applicable	◆ $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	Compliant
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	$40	Not Compliant

Example	Copay	Compliance
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	
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	

Example	Copay	Compliance
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 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: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. We understand that plans may have drug benefits that do not fit neatly into the Plans & Benefits Template. You may translate your cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template using any of the following:

1. Enter the cost-sharing data for the tier in the Prescription Drug Template that has the highest generic drug utilization in 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 that have 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 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 that has 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 correspond to the *1 Month In Network Retail Pharmacy Copayment* and *1 Month In Network Retail Pharmacy 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 *1 Month Out of Network Retail Pharmacy 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. Although tiers are used as a framework to group drugs in the Prescription Drug Template, tiers in the Plans & Benefits Template refer to provider and pharmacy networks. Issuers with multiple in-network tiers for medical benefits may use the tiered cost-sharing field for drugs to represent preferred and non-preferred pharmacies on the Plans & Benefits Template. Following this approach, issuers would enter the cost-sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to *In Network (Tier 1)*.

2. Nonpreferred pharmacy cost sharing corresponds to *In Network (Tier 2)*.

3. Issuers without multiple in-network tiers for their medical benefits do not need to represent nonpreferred pharmacy cost sharing under the Tier 2 fields in the Plans & Benefits Template.

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 to **Not Applicable**.

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

CSR 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 CSRs (45 CFR 156.420). However, you are not required to submit a separate formulary in the Prescription Drug Template for plan variations.

Regardless of how you 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 used in the AV calculation.

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Table 2D-9 and Table 2D-10 list the Plans & Benefits Template data elements that we anticipate displaying on Plan Compare. This list is not final and may change after these instructions are published, but you should use it as a reference as you prepare your QHP Application.

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

Plan Compare Label Name	Template Value	Data Source
Deductibles and Maximum Out of Pocket Rules	◆ If medical and drug amounts are integrated, the combined amount will display. ◆ If medical and drug amounts are not integrated, only the medical amount will display on the Plan Summary page. (The drug amount will display in the Prescription Drug Details section.) ◆ If there is only one person in the enrollment group, the Individual Per Person amount will display. ◆ If there is more than one person in the enrollment group, the Family Per Group amount will display. The dollar amount will display followed by the text "Per Group." ◆ If there is more than one person in the enrollment group and the plan design does not have a per-group deductible, the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by the text "Per Person."	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in 4.16–18)	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 4.16–18)	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

Plan Compare Label Name	Template Value	Data Source
Provider Directory	Network URL	Network ID Template
Insurance Company + Plan Marketing Name + Plan Type (Issuer Legal Name as recorded in HIOS will display if the Issuer Exchange Marketing Name is null)	Issuer Exchange Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
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 the 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
Benefit Data Rules (These data display for each covered benefit below when the *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
Heath Savings Account Eligible Plan	HSA-Eligible	Plans & Benefits Template

Plan Compare Label Name	Template Value	Template Source
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template
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 the *Medical & Drug Deductibles Integrated?* value is **Yes**, the text "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 the *Medical & Drug MOOP Integrated?* value is **Yes**, the text "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
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

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
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
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

This section lists the anticipated display logic for the deductible, MOOP, copay, and coinsurance cost sharing on Plan Compare for Individual market coverage that is effective starting January 1, 2022. It covers most situations

but is not exhaustive. This list is not final and may change after these instructions are published, but you should use it as a reference as you prepare your QHP Application.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug MOOP and deductible amounts are integrated, the combined total for the medical and drug data element will display on the Plan Summary page. The text "Included with Medical" will display on the Plan Details page under the drug amounts.

- If medical and drug MOOP and deductible amounts are not integrated, only the medical amount will display on the Plan Summary page. The drug amount will display in the Prescription Drug Details section on the Plan Details page.

- If there is only one person in the enrollment group, the individual MOOP and deductible amounts will display on the Plan Summary and Plan Details pages.

- If more than one person is in the enrollment group, the Family Per Group MOOP amount will display on the Plan Summary page. The dollar amount will display followed by the text "Per Group."

- If there is more than one person in the enrollment group and if you entered **$0** or a positive dollar amount for *Family Per Group*, the Family Per Group deductible amount will display on the Plan Summary page. The dollar amount will display followed by the text "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., you entered **Not Applicable** for the Family Per Group Deductible), then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by the text "Per Person."

- On the Plan Details page, the Family Per Group and Family Per Person deductible and MOOP amounts will display.

- The out-of-network deductible and MOOP will not display on Plan Compare.

5.10.2 Covered Benefit Plan Compare Display Logic

- The Plan Compare display logic considers the entered values for both 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 will display.

- When copay is greater than zero and coinsurance is **Not Applicable**, the entered copay value will display.

- If coinsurance is equal to **100%**, a benefit will display as Not Covered.

- No Charge After Deductible will display if one of the following occurs:

    - The issuer entered **No Charge After Deductible** for copay and coinsurance.

    - The issuer entered **Not Applicable** for copay and **No Charge After Deductible** for coinsurance, or vice versa.

- No Charge will display 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 will display.

- When copay and coinsurance are each greater than zero, both will display.

5.11 Troubleshooting the Plans & Benefits Add-In File

If you open the Plans & Benefits Add-In file before the template, Excel sometimes loads an older version of the Add-In file that is not compatible with the template, which can cause run-time errors when you are entering data in 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 the best results.

2. <u>Never</u> rename the Add-In file.

3. Delete all extra copies of the Add-In file on the computer. When you download a new copy or version of the Add-In file, always choose the option to replace the old version.

If you still experience run-time errors, Excel may have loaded a previous version of the Add-In file, do the following to remove the previous version:

1. Open a new blank sheet in Excel. Excel should not load the **Plans & Benefits** ribbon.

   a. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (Figure 2D-19, Figure 2D-20, and Figure 2D-21).

2. Verify that the **Plans & Benefits** ribbon is gone. Ensure you have only the correct version of the Add-in file on your computer.

3. Open the Plans & Benefits Template.

4. If the template opens the Add-In automatically after you click **Enable Macros**, the template has successfully loaded the Add-In.

Figure 2D-19. Excel Options Window
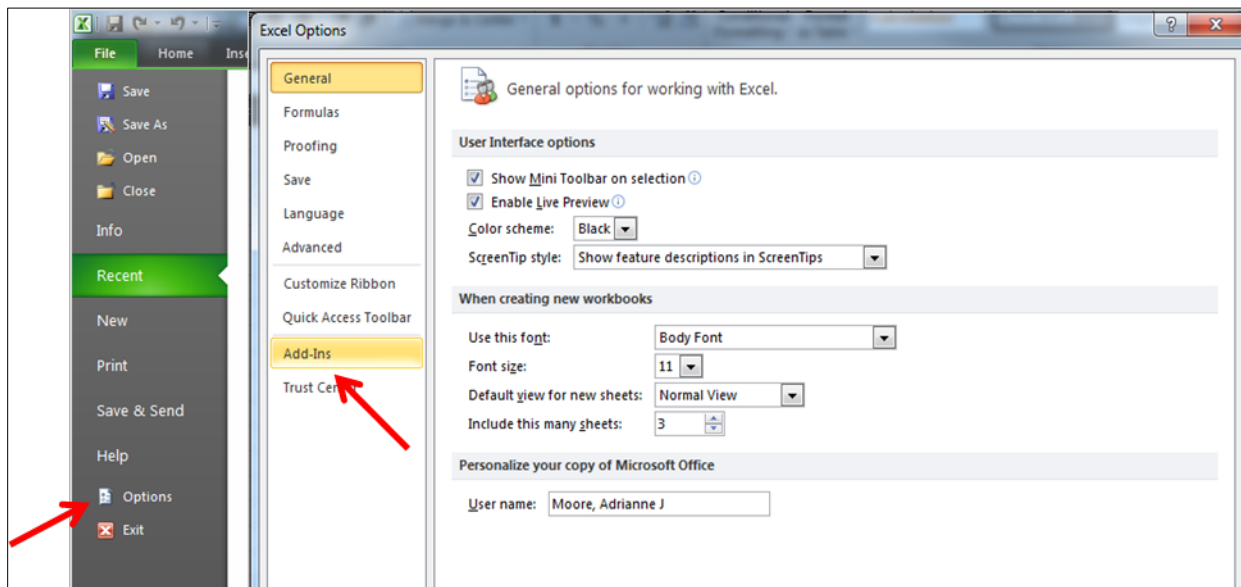
Figure 2D-20. Add-Ins Tab in Excel Options Window
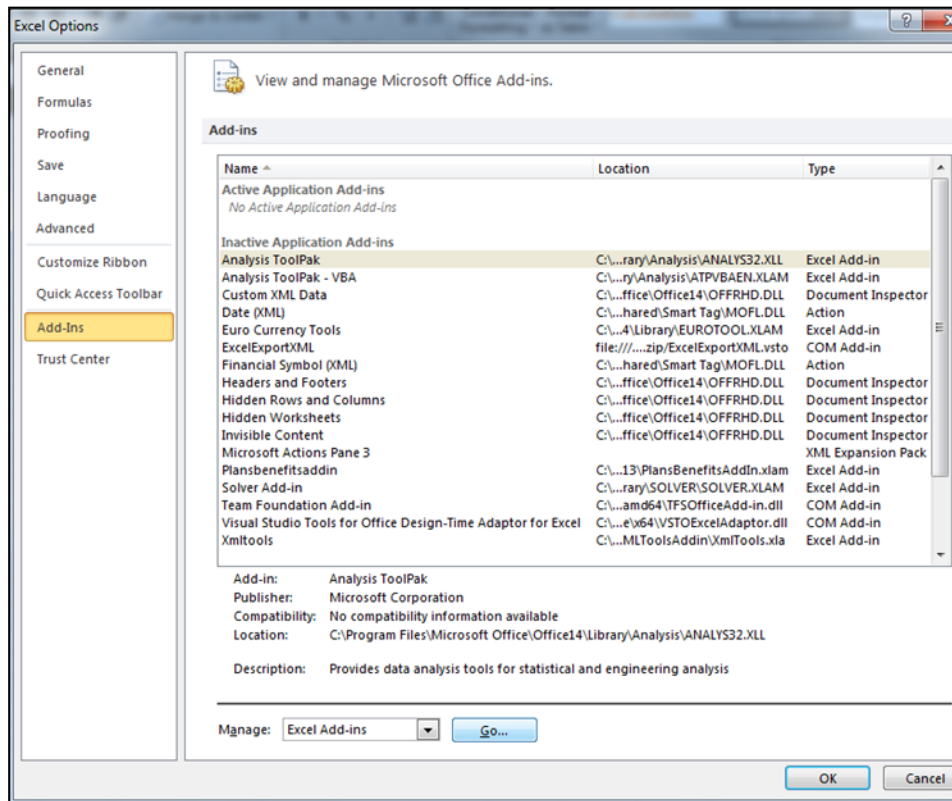
Figure 2D-21. Add-Ins Window
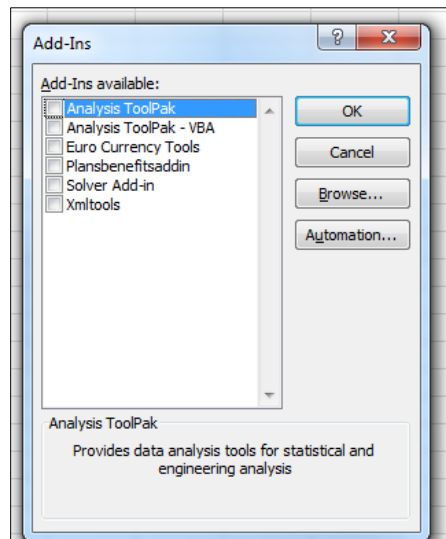
After you have entered all data, click **Save** to ensure no data are lost. The next section of the Instructions for the PY2022 QHP Application is Transparency in Coverage.

Section 2E: Transparency in Coverage

1. Introduction

This document provides instructions for QHP issuers submitting Transparency in Coverage data (transparency data) for PY2022.[1]

If you are submitting a QHP certification application for PY2022, you must make accurate and timely disclosures of transparency reporting[2] information to the appropriate Exchange, the Secretary of HHS, and the state insurance commissioner, and make the information available to the public.[3] These instructions apply to issuers applying for QHP certification in FFEs in PY2022, including issuers in FFEs where states perform plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs). This includes:

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

- On-Exchange Certified Medical QHPs
- On-Exchange Certified SADPs
- Off-Exchange-only Certified SADPs
- SHOP QHPs.

Note: If you're an issuer in an SBE state not on the federal platform, you are not required to submit Transparency in Coverage data at this time.

Exchange Type	Transparency in Coverage Reporting Required?
FFE	Yes
FFE with state performing plan management functions	Yes
SBE using own IT platform	No
SBE-FP (using federal IT platform)	Yes

2. Data Requirements

To complete this section, you will need the following:

- Information on whether the issuer was on the Exchange in 2020
- HIOS Issuer IDs and all PY2022 plan IDs
- Number of PY2020 claims and denials
- Number of PY2020 appeals
- Claims Payment Policy and Other Information URL ("Transparency in Coverage URL").

To apply for PY2022 QHP certification, you must submit a Transparency in Coverage Template that includes all PY2022 plan IDs. You cannot submit your QHP Application without this template. However, only on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2020, through December 31, 2020. Other issuers, including on-Exchange issuers not on the Exchange in PY2020, should complete the template indicating reporting requirements are not applicable.

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[1] Office of Management and Budget Control Number CMS-10572.

[2] Section 2715A of the PHS Act extends the transparency reporting provisions under Section 1311(e)(3) to non-grandfathered groups and issuers offering group or individual coverage, except for a plan not offered on an Exchange.

[3] The implementation of the transparency reporting requirements under Section 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into Section 715(a)(1) of the Employee Retirement Income Security Act and Section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

The Transparency in Coverage Template must include all PY2022 plan IDs submitted in the Plans & Benefits Template. If you have more than one HIOS Issuer ID in a state, you must submit a Transparency in Coverage Template for each unique HIOS Issuer ID. Only report claims data for plan IDs that were offered on the Exchange in PY2020 and will be offered again in PY2022. If a PY2022 plan ID was not offered on the Exchange in PY2020, include it in the template but indicate that PY2020 claims data is not applicable for that plan ID. See Table 2E-1 for a summary of Transparency in Coverage reporting requirements.

If a QHP is available both on and off the Exchange, issuers are required to report claims data <u>only for the on-Exchange enrollees</u>.

Table 2E-1. Summary of Transparency in Coverage Reporting Requirements

Plan Type	Transparency in Coverage Template Required?	Transparency in Coverage Claims Data Required?	Transparency in Coverage URL Required?
On-Exchange QHP that was offered in PY2020	Yes	Yes. Do not include or count claims data for off-Exchange QHP enrollment.	Yes
On-Exchange SADP that was offered in PY2020	Yes	Yes. Do not include claims data for off-Exchange SADP enrollment.	Yes
Off-Exchange SADP that was offered in PY2020	Yes	No. Do not include or count off-Exchange plan IDs or claims data.	No
On-Exchange QHP that was **NOT** offered in PY2020	Yes	No. Note as N/A in the template.	Yes
On-Exchange SADP that was **NOT** offered in PY2020	Yes	No. Note as N/A in the template.	Yes
Off-Exchange SADP that was **NOT** offered in PY2020	Yes	No. Do not include or count off-Exchange plan IDs or claims data.	No

3. Quick Reference

Key Changes for 2022
◆ The deadline for submitting Transparency in Coverage data and the Claims Payment Policies and Other Information URL is now aligned with QHP certification and will be due on June 16, 2021.
◆ The template includes a new validation for SADP-only issuers. Please select **Yes** from the dropdown box on the issuer-level tab if you are an SADP-only issuer. If you are not an SADP-only issuer, you must select **No**.
◆ The instructions for entering data into the Issuer and Plan Level tabs of the Transparency in Coverage Template now include information regarding expected values for specific columns.
◆ Off-Exchange-only plan IDs are no longer required to be entered in the Plan Level tab of the Transparency in Coverage Template.
◆ **PLEASE NOTE: CMS has clarified definitions and expectations for reporting claims received, claims denied, and reasons for denied claims data. The instructions now contain examples to help illustrate these clarifications.**

Tips for the Transparency Section
◆ If you are applying to offer QHPs for PY2022 but did not offer QHPs in 2020, you must still submit a Transparency in Coverage Template.
◆ **Do not include off-Exchange-only plans in the Plan Level tab of the Transparency in Coverage template.**
◆ Required data elements are identified by an asterisk (*) next to the field name. Complete a separate template for each unique HIOS Issuer ID.
◆ Use only the tabs provided in the Transparency in Coverage Template. Do not add additional tabs, rows, or columns. Separate templates should be submitted for each unique HIOS Issuer ID.
◆ Enter all on-Exchange plan-level data in the Plan Level Data tab. One plan ID should be captured in each row. Each plan ID listed should be a distinct 14-character ID.
◆ Check the templates for completeness and data validity before you submit by clicking **Validate** on the Issuer Level Data tab.
◆ The Claims Payment Policies and Other Information URL will be collected in the Supplemental Submission Module (SSM) in HIOS and must be active and compliant with URL requirements at the time of initial submission.
◆ If you are submitting via HIOS, you must upload the completed template to the Benefits and Service Area Module of HIOS by the required deadline.
◆ If you are submitting via SERFF, submit one identical Transparency in Coverage Template containing all plan IDs in each submission binder. For example, if you submit an Individual market binder and a SHOP binder, include both the Individual market plan IDs and the SHOP market plan IDs in one Transparency in Coverage Template and submit it in each binder.

Additional Resources
◆ There are supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

4. Transparency in Coverage Template

Perform the following steps to complete the Transparency in Coverage Template (see Figure 2E-1 and Figure 2E-2).

Note if you are submitting via SERFF: You must include all plan IDs you wish to offer in one Transparency in Coverage Template and submit that template in all binders. The HIOS system allows only one template submission. If you submit two templates in SERFF (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different plan-level information, only the last template your state transfers from SERFF to HIOS will be retained; the information submitted in previous templates will be overwritten. Adding all plan IDs associated with a HIOS Issuer ID to a single template and using it for all binders associated with that HIOS Issuer ID will help you avoid problems related to SERFF overwrite rules.

Example of Successful SERFF Issuer Submission: If you have an Individual market SERFF binder with 3 plan IDs and a SHOP SERFF binder with 7 plan IDs, you should submit identical Transparency in Coverage Templates containing all 10 plan IDs in both binders. Although the first Transparency in Coverage Template will be overwritten by the second, because you have entered all 10 plan IDs in both templates, you will not lose any information and you will submit successfully.

Figure 2E-1. Transparency in Coverage Template

	OMB control number: 0938-1310/Expiration date: 04/22/2022
*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.*	
Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2022 v2.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2020?*	
SADP Only?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	
Notes:	
Please enter any comments/notes here.	

Note: If you were not on the Exchange in 2020 or will offer off-Exchange SADPs for 2022, please mark **N/A** for all claims data fields.

4.1 Issuer Level Data Tab

General Information	Steps
Was this issuer on the Exchange in 2020?*	Enter **Yes** or **No** to indicate whether or not this issuer was on the Exchange in 2020. ◆ If **Yes**, the issuer must fill out claims and appeals data. ◆ If **No**, the issuer must enter **N/A** in the claims and appeals data fields. ◆ If the issuer offers only off-Exchange SADPs, enter **No**.
Issuer HIOS ID*	Enter your five-digit HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID.
SADP Only?	Select **Yes** or **No** from the drop-down menu to indicate whether you offer only SADPs.

Issuer Level Data	Steps
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	Enter the number of issuer-level claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of your network (such as an HMO or PPO). Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value. ◆ A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims). ◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID. ◆ **Claims that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim:** ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason.

Issuer Level Data	Steps
	Do not include out-of-network claims. <u>The value you submit in this field must include in-network claims for all QHPs in 2020, including QHPs not offered in 2022</u>. Therefore, the plan-level claims reported elsewhere in the template may not add to the issuer-level claims reported here.

Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Enter the number of issuer-level claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of your network (such as an HMO or PPO) that you subsequently denied.
	
	◆ A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims).
	◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID.
	◆ **Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:**
	  ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity.
	  ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial.
	◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately.
	◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2020, including:
	  ▪ Pediatric vision and dental denials, including SADPs
	  ▪ Denials because of ineligibility
	  ▪ Denials caused by incorrect submission
	  ▪ Denials caused by incorrect billing
	  ▪ Duplicate claims.
	◆ **Do not include out-of-network claims.**
	The value you submit in this field must include in-network denied claims for <u>all</u> QHPs in 2020, including QHPs not returning to the Exchange in 2022. Therefore, the sum of plan-level denied claims reported elsewhere in the template may be less than the issuer-level denied claims reported here.

Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	Enter the number of requests for internal appeals involving adverse determinations you received from consumers pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage. Include appeals regarding services with DOS in 2020 that you received, fully adjudicated, and completed in 2020. Do not include appeals that were subsequently withdrawn. CMS expects the number of issuer-level internal appeals reported here to be less than the Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for internal review, <u>in whole or in part</u>, pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage.

Issuer Level Data	Steps
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	Enter the number of requests for external appeals of final adverse determinations consumers sent to an external review organization pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals regarding services with DOS in 2020 that you received, fully adjudicated, and completed in 2020. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for external review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

Figure 2E-2. Transparency in Coverage Template—Plan Level Tab

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting									
Plan Year 2022									
Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, *excluding* Behavioral Health in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health *only*, in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020*	Notes: (Please enter any comments/notes here.)

You must include all on-Exchange plan IDs that are present in your PY2022 QHP Application in the Transparency in Coverage Template. If you were not on the Exchange in 2020, enter **N/A** in the claims data fields.

Note: Report all reasons a claim is denied. A claim can be denied for more than one reason. Therefore, the sum of the reasons why claims were denied may either be equal to or greater than the *Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*.

4.2 Plan Level Data Tab

PY2022 Plan Data	Steps
2022 On-Exchange Plan ID*	Enter the 14-character PY2022 On-Exchange plan ID on the Plan Level Data tab. The plan ID is composed of the five-digit HIOS Issuer ID, the two-character state abbreviation, and the seven unique digits for the plan (e.g., 12345AZ1234567). If there is more than one PY2022 plan ID to report for a single HIOS Issuer ID, add each plan line-by-line in the Plan Level Data tab. All plan variants should be rolled up to one plan ID or line in the template. For example: ◆ Reported claims for 12345AZ1234567 would include claims that fall under this plan ID from members on all associated plan variants: ▪ 12345AZ1234567-01: 100 claims ▪ 12345AZ1234567-02: 500 claims ▪ 12345AZ1234567-03: 200 claims ▪ 12345AZ1234567-04: 50 claims. Reporting for plan ID 12345AZ1234567 should be entered as one plan ID in one row of the template with a total of 850 claims (100 + 500+ 200+ 50) for the applicable data field.
Number of Plan Level Claims with DOSs in 2020 That Were Also Received in Calendar Year 2020*	Enter the number of in-network plan-level claims you received that asked for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of your network (such as an HMO or PPO). Include pediatric dental and vision claims. Count claims by DOS and report claims data

PY2022 Plan Data	Steps

	with a single numerical value. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u>
	
	◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims).
	◆ Include claims for all QHPs that fall under the reporting plan ID.
	◆ Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 4 should only be counted once. For example, the following each count as one claim:
	  ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service.
	  ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims.
	
	The total issuer-level claims received data may include plans not offered in 2022. Therefore, the plan-level claims total may not total the issuer-level claims.

Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020[4] (Plan Level Claims Denied)*	Enter the number of <u>plan-level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that you subsequently denied. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable</u>.
	
	◆ A claim is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims).
	◆ Include claims for all QHPs that fall under the reporting plan ID.
	◆ **Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:**
	  ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity.
	  ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial.
	◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately.

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[4] For example, if one of your plans were to receive 20,000 claims and deny 3,000 of those claims, you would further report the reasons for the 3,000 denials in one or more of six denial categories:
1. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020
2. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020
3. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020
4. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2020
5. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2020
6. Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020.

In this example, you could report more than 3,000 <u>denial reasons</u> in the six reporting categories if claims were denied for more than one reason, but would only report 3,000 plan-level claims were <u>denied</u>.

PY2022 Plan Data	Steps

	◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2020, including:
	  ▪ Pediatric vision and dental denials, including for SADPs
	  ▪ Denials because of ineligibility
	  ▪ Denials caused by incorrect submission
	  ▪ Denials caused by incorrect billing
	  ▪ Duplicate claims.
	◆ Do not include out-of-network claims.
	The total number of plan-level claims denied in the specified calendar year should also be accounted for in the six Plan Level Claims Denial categories. *Note that CMS expects the sum of the six Plan Level Claims Denial categories to be greater than or equal to the Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020 because individual claims may be denied for more than one reason.*

Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020
 	
(Plan Level Claims Denied)*
	NOTE: The following claim denial reporting instructions for Columns D, E, F, G, H, and I of the plan-level tab are different than the instructions for claim denial reporting on the issuer-level tab and Column C of the plan-level tab. Rather than reporting denied claims based on their final adjudication, report each incidence of the following denials that occur throughout the life of a claim. For example:
	◆ **For the Issuer-Level tab and Column C of the plan-level tab:**
	  ▪ **If a claim is denied for any reason, then resubmitted and denied again without further resubmission, it will count as one denied claim.**
	◆ **For Columns D, E, F, G, H, and I:**
	  ▪ **If a claim is denied for lacking a prior authorization and being an excluded service, then resubmitted and denied again for lacking a prior authorization and being an excluded service, it will count twice in Column D (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020), and twice in Column F (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020).**
	
	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for non-emergency-related claims for service that required prior authorization, preauthorization, referral, prior approval, or precertification; in this instance, the claim was denied for plans that require a prior or preauthorization, referral, prior approval, or precertification beginning from when a claim was first received to its final adjudication. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u>
	
	Issuers should include the following claims (individual claim line of service items):
	◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied.
	◆ Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification.
	◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims).
	◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:**
	  ▪ If a claim is denied for requiring a prior authorization, resubmitted, and denied again for the same reason, it will count as two denials in this category.
	  ▪ If a claim is denied for requiring a prior authorization, resubmitted with the required documentation, and paid, it will count as one denial in this category.
	
	Include claims for all QHPs that fall under the reporting plan ID. Do not include out-of-network claims.

PY2022 Plan Data	Steps
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>plan-level</u> denials you issued for claims for service from outside the plan's network of health care providers if the plan has a closed network beginning from when a claim was first received to its final adjudication. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u> Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for point of service benefits provided by someone (e.g., health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plan's (HMO or closed network plans) network. ◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** 　▪ If a claim is denied for services from an out-of-network provider, resubmitted, and denied again for the same reason, it will count as two denials in this category. 　▪ If a claim is denied for services from an out-of-network provider, resubmitted with updated documentation, and paid, it will count as one denial in this category. ◆ **Do not include in-network claims.**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for claims for excluded or non-covered services. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u> Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because certain services, tests, treatments, admissions, supplies, etc., are excluded, not covered, or limited under the plan, including claims denied as a result of a drug not being on the formulary. ◆ A claim is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** 　▪ If a claim is denied as an excluded service, resubmitted, and denied again for the same reason, it will count as two denials in this category. 　▪ If a claim is denied as an excluded service, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health</u>, in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u> Include the following denials for lack of medical necessity (individual claim line of service item): ◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. ◆ Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: 　▪ Analgesics

PY2022 Plan Data	Steps
	▪ Anesthetics
	▪ Antibacterials
	▪ Anticonvulsants
	▪ Antidementia Agents
	▪ Antiemetics
	▪ Antifungals
	▪ Antigout
	▪ Antimigraine Agents
	▪ Antimyasthenic Agents
	▪ Antimycobacterials
	▪ Antineoplastics
	▪ Antiparasitics
	▪ Antiparkinson Agents
	▪ Antipasticity Agents
	▪ Antivirals
	▪ Blood Glucose Regulators
	▪ Blood Products and Modifiers
	▪ Cardiovascular Agents
	▪ Central Nervous System Agents
	▪ Dental and Oral Agents
	▪ Dermatological Agents
	▪ Electrolytes/Minerals/Metals/Vitamins
	▪ Gastrointestinal Agents
	▪ Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment
	▪ Genitourinary Agents
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)
	▪ Hormonal Agents, Suppressant (Adrenal)
	▪ Hormonal Agents, Suppressant (Pituitary)
	▪ Hormonal Agents, Suppressant (Thyroid)
	▪ Immunological Agents
	▪ Inflammatory Bowel Disease Agents
	▪ Metabolic Bone Disease Agents
	▪ Ophthalmic Agents
	▪ Otic Agents
	▪ Respiratory Tract/Pulmonary Agents
	▪ Skeletal Muscle Relaxants
	▪ Sleep Disorder Agents.
	Do not include the following claims:
	◆ Behavioral or mental health claims or payment for services.
	▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders.
	▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Report claims as

PY2022 Plan Data	Steps
	behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD. ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied due to lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied due to lacking medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health only</u>, in Calendar Year 2020 (Plan Level Claims Denied)	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat illness, injury, condition disease, or the symptoms of these related to behavioral or mental health beginning from when a claim was first received to its final adjudication. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans must enter a value in this field; 0 is acceptable. If you responded **Yes** to *SADP Only* on the Issuer Level Data tab, no action is required</u>. ◆ Issuers should include the following claims denials for lack of medical necessity (individual claim line of service items): Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health. ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the DSM and the ICD. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD as well as federal or state guidelines. ◆ Issuers should use the following USP drug categories to count pharmacy claims including behavioral health: ▪ Anti-addiction/substance abuse treatment agents ▪ Antidepressants ▪ Antipsychotics ▪ Anxiolytics ▪ Bipolar agents. ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied due to lack of medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category. Do not include the following: ◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. ◆ Out-of-network claims.

PY2022 Plan Data	Steps
Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020 (Plan Level Claims Denied)	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for claims rejected for reasons other than those specified above beginning from when a claim was first received to its final adjudication. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u> Issuers should include the following claims (individual claim line of service items): ◆ Incorrect bill coding ◆ Patient not insured by the plan ◆ Coverage terminated ◆ Duplicate claims ◆ Coordination of benefits issues/failures ◆ Untimely claims filings based on an issuers timeframe for filing a claim ◆ Denial because a procedure is considered experimental, cosmetic, or investigational ◆ **Any other claim denied for any services not appropriate for the previous plan-level categories.** ◆ **Include all instances of a denial that falls in the "other" category throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted, and denied again for the same reasons, it will count as **four** denials in this category. ▪ If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted with updated documentation, and paid, it will count as **two** denials in this category. Do not include out-of-network claims.

Verify the following before submitting the PY2022 Transparency in Coverage template:

- Issuer-level claims received reported on the Issuer Level tab is greater than or equal to the sum of claims received across all plan IDs on the Plan Level tab.

- Issuer-level claims denied reported on the Issuer Level tab is greater than or equal to the sum of claims denied across all plan IDs on the Plan Level tab.

- Issuer-level claims denied reported on the Issuer Level tab is greater than or equal to the Number of Issuer Level Internal Appeals Filed in Calendar Year 2020.

- Sum of Plan Level reasons for denied claims (Columns D, E, F, G, H, and I) is greater than or equal to reported claims denied (Column C) for each plan ID.

4.3 Transparency in Coverage Template Submission for Issuers Not Subject to Reporting Requirements

To apply for PY2022 QHP certification, you must submit a Transparency in Coverage Template that includes all your PY2022 plan IDs. You cannot submit your QHP Application without this template. However, the following issuers are not required to submit Transparency in Coverage data as described in 4.1 Issuer Level Data Tab and 4.2 Plan Level Data Tab:

- Issuers that are new to the Exchange

- Off-exchange certified SADPs.

<u>Off-Exchange-only issuers (non-QHP) that are not seeking certification</u> are not required to submit a Transparency in Coverage Template and do not have a data reporting requirement at this time.

This section describes how to submit the Transparency in Coverage Template without reporting numerical transparency data. You will enter a **HIOS Issuer ID** in the Issuer Level Data tab (Figure 2E-3) and all PY2022 plan IDs in the Plan Level Data tab (Figure 2E-4). **N/A** must be entered in data fields as indicated below.

4.3.1 Issuers With no Data Reporting Requirement—Issuer Level Data Tab

General Information	Expected Value
Was this issuer on the Exchange in 2020?*	No
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID.

Issuer Level Data	Expected Value
Number of Issuer Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	**N/A**
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	**N/A**
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	**N/A**
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	**N/A**
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	**N/A**
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	**N/A**

Figure 2E-3. Sample Data Template With No Reporting Requirement—Issuer Level Tab

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting Plan Year 2022 v2.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2020?*	No
SADP Only?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	N/A
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	N/A

4.3.2 Issuers With no Reporting Requirement—Plan Level Data Tab

Plan Level Data	Expected Value
2022 On-Exchange Plan ID*	Enter the 14-character PY2022 plan ID on the Plan Level Data tab. You must include all on-Exchange plan IDs present in your QHP Application (do not include plan IDs for off-Exchange only plans) on the Plan Level Data tab.
Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	**N/A**

Plan Level Data	Expected Value
Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2020 (Plan Level Claims Denied)	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020 (Plan Level Claims Denied)	**N/A**

Figure 2E-4. Sample Data Template With No Reporting Requirement—Plan Level Tab

Plan Year 2022									
Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, *excluding* Behavioral Health in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health *only*, in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020*	Notes: (Please enter any comments/notes here.)
11111VA1111111	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

5. Claims Payment Policy and Other Information URL

To apply for PY2022 QHP certification, you must enter a Transparency in Coverage URL in the SSM, including those with off-Exchange SADP offerings. You cannot submit your network URLs without submitting the Transparency in Coverage URL at the same time as or before the network URLs.

Although a URL submission is required to apply for PY2022 QHP certification, you are required to submit an active URL that directs to a compliant claims payment policy website only if you offer on-Exchange QHPs and SADPs. If you offer only off-Exchange SADP offerings, complete the SSM using **http://temporary.url**.

Issuer Type	Acceptable URL Submission
QHP issuer	Active URL directing to compliant claims payment policies
Other issuers (e.g., issuers with only off-Exchange SADP offerings)	**http://temporary.url**

The Claims Payment Policy and Other Information URL will be collected in the SSM in HIOS. Please refer to the SSM user guide for instructions on how to submit the URL. The information below provides an overview of the information you must include on the Transparency in Coverage URL's web page and examples of how you might explain it.

PY2022 URL Contents	Minimum Requirements
Claims Payment Policies & Other Information URL	Enter the active and easily accessible URL. Ensure it meets the following requirements: ◆ It can be viewed on the plan's public website via a clearly identifiable link or tab on the issuer's home or marketplace plan landing page without requiring an individual to create or access an account or enter a policy number ◆ An individual can easily discern which information applies to each plan the issuer offers. The URL is the web address on the issuer website that directs consumers to the page on your website they can use to view pertinent information about your practices. All URLs should be live and compliant when you submit them, with one URL for a landing page or a single page with one or more links providing the information indicated below. If you have unique HIOS Issuer IDs in the same state and the Transparency in Coverage information is the same across the HIOS Issuer IDs, you may submit the same URL for all HIOS Issuer IDs. Note: If the URL or website content refers to the plan year, it should refer to the plan year of the current application submission, not the plan year of the claims data.
Out-of-network liability and balance billing	Description: ◆ Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or the amount remaining on a deductible. Provide: ◆ Information regarding whether a consumer may have financial liability for out-of-network services. ◆ Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act. ◆ Information regarding whether a consumer may be balance billed. You do not need to include specific dollar amounts for out-of-network liability or balance billing. Example of Acceptable Consumer-Facing Language: Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.
Enrollee claim submission	Description: ◆ An enrollee submits a claim instead of the provider, requesting payment for services received. Provide: ◆ General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, indicate this here. ◆ A time limit to submit a claim, if applicable. ◆ Links to any applicable forms. All forms must be easily identifiable and publicly accessible. ◆ Describe how an enrollee can submit a claim if you do not require any forms. List any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission. ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. Example of Acceptable Consumer-Facing Language: A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. Please contact customer service at [phone number] to determine the specific time limit for submitting your claim.

PY2022 URL Contents	Minimum Requirements
	To file a claim, follow these steps: 1. Complete a claim form [Claim Form Link]. 2. Attach an itemized bill from the provider for the covered service. 3. Make a copy for your records. 4. Mail your claim to the address below. [Company Name] [P.O Box 1234] [City, State, ZIP Code] 5. Alternatively, you can send the information by email to [claims-submissions@companyname.com] or by fax to [123-456-7890].
Grace periods and claims pending	Description: ◆ If you are a QHP issuer, you must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, you must provide an explanation of the 90-day grace period for enrollees with premium tax credits, pursuant to 45 CFR 156.270(d). Provide: ◆ An explanation of what a grace period is. ◆ An explanation of what claims pending is. ◆ An explanation that you will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. Example of Acceptable Consumer-Facing Language: You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in [state], we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period. If you are enrolled in an individual health care plan offered on the *Health Insurance Marketplace* and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.
Retroactive denials	Description: ◆ A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment. Provide: ◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable. ◆ Ways to prevent retroactive denials when possible, such as paying premiums on time. Example of Acceptable Consumer-Facing Language: A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.

PY2022 URL Contents	Minimum Requirements
	You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service performed is a covered benefit. You can also avoid retroactive denials by obtaining your medical services from an in-network provider.
Recoupment of overpayments	Description: ◆ If you overbill an enrollee for a premium, they may use recoupment of overpayments to obtain a refund. Provide: ◆ Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact. Example of Acceptable Consumer-Facing Language: If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.
Medical necessity and prior authorization timeframes and enrollee responsibilities	Description: ◆ Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. ◆ Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit. Provide: ◆ An explanation that some services may require prior authorization and may be subject to review for medical necessity. ◆ Any ramifications should the enrollee not follow proper prior authorization procedures. ◆ A timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable. Example of Acceptable Consumer-Facing Language: We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.
Drug exception timeframes and enrollee responsibilities (not required for SADPs)	Description: ◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c). Provide: ◆ An explanation of the internal exceptions process for people to obtain non-formulary drugs. ◆ An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or Independent Review Organization (IRO). ◆ Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. ◆ Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact. Example of Acceptable Consumer-Facing Language: Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form [link provided here]. If the drug is denied, you have the right to an external review.

PY2022 URL Contents	Minimum Requirements
	If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision. An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request: [Request Form Link] [Address] [Phone] [Fax]. For standard exception review of medical requests where the request was denied, the timeframe for review is 72 hours from when we receive the request. For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.
Explanation of benefits (EOB)	Description: ◆ An EOB is a statement you send an enrollee that lists the medical treatments or services you paid for on an enrollee's behalf, what you paid, and the enrollee's financial responsibility pursuant to the terms of the policy. Provide: ◆ An explanation of what an EOB is. ◆ Information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. Example of Acceptable Consumer-Facing Language: Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.
Coordination of benefits (COB)	Description: ◆ COB allows an enrollee who is covered by more than one plan to determine which plan pays first. Provide: ◆ An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). Example of Acceptable Consumer-Facing Language: Coordination of benefits, or COB, is when you are covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about coordination of benefits can be found in your benefit booklet.

After you complete the template, submit it in the Benefits and Service Area Module of HIOS and submit your Transparency in Coverage URL in the SSM. If you are submitting via SERFF, submit your Transparency in Coverage Template in your SERFF binders. To resubmit or correct any data errors, follow the resubmission steps in these instructions. If you need to correct URL errors, you should update your live URL page.

After you have entered all data, click **Save** to ensure no data are lost. This completes the Instructions for the Benefits and Service Area Module of the PY2022 QHP Application. The next section of the Instructions for the PY2022 QHP Application is the Rating Module.

3. Rating Module

Users of the Rating Module are assigned to one or both of the following roles: Rating Submitter (an individual who submits the data necessary to complete the Rating Module) and Rating Validator (an individual who verifies that all sections of the Rating Module are accurate).

This module is organized by its application sections, and consists of the Summary, Data Submitter, Data Validator, and Final Submission pages.

The Summary page is the first page visible when navigating to the Rating Module. You will use it to start a new application, resume a pending application, or view a submitted application for the HIOS Issuer IDs in which you have access.

The Data Submitter page allows Rating Submitters to upload completed Rates Table Template (for both medical and dental plans) and Business Rules Template .XML files to the system by selecting the document type (Rates or Business Rules) from the dropdown, clicking **Browse**, selecting the completed template file, and clicking **Upload** (see Figure 3-1). Each time you upload one of these templates, the new version will replace the previous version.

The Data Validator page allows Rating Validators to download and view submitted Rates Table or Business Rules templates to validate that the data are correct (Figure 3-2).

The Final Submission page allows the Rating Submitter and Rating Validator to cross-validate data between modules, and allows the Rating Validator to submit the QHP Application (Figure 3-3).

Each tab provides information that you need to enter to create a new application or edit an existing application. You must complete all sections listed in the lower-left part of the Data Submitter page before beginning work on the Data Validator page.

Figure 3-1. Data Submitter Page

Figure 3-2. Data Validator Page

| 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 3-3. Final Submission Page

| 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, enter rate information for each plan you offer in a Rating Area. If you offer both medical and dental plans and if you submit your Qualified Health Plan (QHP) Application in the Health Insurance Oversight System (HIOS), you must submit a single Rates Table Template that contains rate data for all your plans (QHPs and stand-alone dental plans [SADPs]).

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2022
◆ If you submit in HIOS, you must submit a single Rates Table Template that contains rate data for all your plans (QHPs and SADPs). If you submit via the System for Electronic Rates and Forms Filing (SERFF), this requirement does not apply.

Tips for the Rates Table Section
◆ Use separate worksheets in the Rates Table Template for medical plans and dental plans.
◆ Use separate worksheets for Individual market plans and Small Business Health Options Program (SHOP) plans.
◆ For Individual market plans, the rate effective date must be January 1, 2022.
◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet is bound to a separate effective date range. If you submit SHOP trended quarterly rates, you must submit a separate worksheet for each date range that a set of rates will be effective.

Additional Resources
◆ There are no supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

Complete the Rates Table Template using the steps outlined below to provide rate information. You cannot validate until all required fields are completed.

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit **HIOS Issuer ID**.
Rate Effective Date	Enter the rate effective date as **mm/dd/yyyy**. For Individual market plans, the rate effective date must be **01/01/2022**. ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet in the Rates Table Template is bound to a separate effective date range. If you submit SHOP trended quarterly rates, you must submit a separate worksheet for each date range that a set of rates will be effective.

Rates Table Template	Steps
	◆ If you submit a SHOP quarterly rate change, you must submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable data change submission window. An issuer may submit rate changes that would apply for the next quarter or any subsequent quarter in the remaining plan year. An issuer must not change or delete rates from the template 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 must match the original submission that contained the rates offered during the first quarter. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding Unified Rate Review Template (URRT).
Rate Expiration Date	Enter the rate expiration date as **mm/dd/yyyy**. ◆ For Individual market plans, the rate expiration date must be **12/31/2022**. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (**03/31/2022**, **06/31/2022**, **09/31/2022**, and **12/31/2022**).
Rating Method	Select whether the plans on the worksheet use **Age-Based Rates** or **Family-Tier Rates**. 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 SADPs are eligible to select **Family-Tier Rates**. A list of states that use family-tier rating is available on the State Specific Rating Variations page.
Add Sheets	Click **Add Sheet** to add additional worksheets for the following: ◆ To separate SHOP plans with different rate effective and expiration dates. All plans on a single worksheet <u>must</u> have the same rate effective and rate expiration dates. ◆ To separate Individual market plans and SHOP plans. ◆ To separate medical plans and dental plans. ◆ To separate plans that use age-based rating and family-tier rating. ◆ To separate by rating area.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (12345AZ1234567) 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 on the State Specific Geographic Rating Areas page. If a set of rates is allowed to be offered in more than one rating area, issuers can elect to assign the set of rates to multiple rating areas within a template worksheet.
Tobacco	If you use age-based rates, select from the following to indicate whether rates vary based on tobacco use: ◆ **Tobacco User/Non-Tobacco User**—if rates differ for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require QHP tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.[1] QHPs rating by tobacco use may not apply tobacco rating to individuals age 0–20, for whom the sale and use of tobacco products is prohibited under federal law. For each underage tobacco age band (0–14, 15, 16, 17, 18, 19, and 20), enter the same rate values under *Individual (non-tobacco) Rate* and *Individual Tobacco Rate*. This entry will prevent application of unique tobacco rating to an underage enrollee. To offer small-group market medical plans (including SHOP QHPs) with tobacco rating, you must offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the Public Health Service (PHS) Act and indicate the wellness program on your Plans & Benefits Template. If you do not offer such a wellness program, the small-group market medical plan cannot rate for tobacco use. ◆ **No Preference**—if the rate applies to tobacco and non-tobacco users. No separate rates are submitted for tobacco and non-tobacco users.

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[1] 42 U.S.C. 300gg—Fair Health Insurance Premiums.

Rates Table Template	Steps
Age	If you use age-banded rates, the template will automatically generate a row for each age band from 0–14 through 64 and over. ♦ If you elect to rate by tobacco use and enter the non-tobacco rates first for the underage age bands of 0–14 through 20, the worksheet will auto-populate the tobacco-rate for each band with the non-tobacco rate. Note for dental plans only: 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 Plan Attributes section of the Plans & Benefits Template, SADP issuers have the option to elect by plan ID 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. ♦ If the issuer is in a state that does not permit rating for age or tobacco use and that establishes uniform family tiers (and corresponding multipliers) or is entering rates for an SADP using Family-Tier Rates as the rating method, skip to Family Tier.
Individual Rate	♦ Enter the individual rate that applies to the plan ID. Market rules limit individual rate variation based on age to not more than three times the 21-age 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 your state's age-rating curve if it is within the 1:3 market rule. A list of states using state-specific age curve variations is available on the State Specific Rating Variations page. Note: QHPs and SADPs must enter a value above $0.00 for all age bands under the Individual Rate column unless you responded **Allows Child-Only** under *Child-only Offering* in 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. ♦ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under *Individual Tobacco Rate* for age bands 21 through 64 and over. For the 0 through 20 age bands, QHPs must enter the same value as the non-tobacco rate under *Individual Tobacco Rate* to avoid applying tobacco rating to enrollees. For QHPs, tobacco rating cannot be applied to individuals age 0–20, for whom the sale and use of tobacco products is prohibited under federal law.
Family Tier	If your state does not permit rating for age or tobacco use and has established uniform family tiers and corresponding multipliers or if you are issuing SADPs and selected **Family-Tier Rates** in *Rating Method*, enter the individual rate in *Individual Rate*. Selecting **Family-Tier Rates** will also generate the following family tier columns: ♦ *Individual Rate* (required): Enter the rate of an individual primary subscriber. ♦ *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 if Life Partner is 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 three 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 three or more dependents. Note: A dependent is defined as any dependent relationship you allow 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.

See Figure 3A-1 for an example of a completed Rates Table Template when **Age-Based Rates** is selected.

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

2022 Rates Table Template v11.0	*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.*			
Validate	*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.			
Finalize	*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.			
HIOS Issuer ID* 12345				
Rate Effective Date* 1/1/2020				
Rate Expiration Date* 12/31/2020				
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

See Figure 3A-2 for an example of a completed Rates Table Template when **Family-Tier Rates** is selected.

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

2022 Rates Table Template v11.0	*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.*				
Validate	*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.				
Finalize	*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.				
HIOS Issuer ID* 12345					
Rate Effective Date* 1/1/2020					
Rate Expiration Date* 12/31/2020					
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*
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
12345AB1234567	Rating Area 1	10.00	20.00	15.00	25.00

After you enter all data, click **Save** to ensure no data are lost. Once the Rates Table Template is completed, you must validate, finalize, and upload it into HIOS.

Template Validation	Steps
Validate Template	Click **Validate** 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 reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved. The template will notify you when there are no errors with the callout box message "This Template is Valid!"
Finalize Template	Click **Finalize** in the template to create the .XML version of the template you will upload in the Rates section of the Rating Module in HIOS.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Rates section of the Rating Module in HIOS. Refer to 3. Rating Module for details on how to complete this step.

After you enter all data, click **Save** to ensure no data are lost. The next section of the Instructions for the PY2022 QHP Application is Business Rules.

Section 3B: Business Rules

1. Introduction

In the Business Rules section, you will enter information that is used to calculate rates and determine enrollee eligibility for coverage under a plan.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the Business Rules Section
◆ Enter values for *HIOS Issuer ID* and *Medical, Dental, or Both?* before entering data for the rest of the template. All other fields are locked until you respond to *Medical, Dental, or Both?*   ◆ All rules associated with Individual market and SHOP market plans must be entered in a single Business Rules Template.   ◆ The first row of rules (row 10) is the base set of issuer business rules. Leave the product ID and plan ID fields blank in this row, but enter data 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. Define how product or plan rules differ from the base set of issuer business rules in the subsequent rows.

Additional Resources
◆ There are no supporting documents for this section.   ◆ There are instructional videos for this section.   ◆ There are templates for this section.

4. Detailed Section Instructions

Note if you are submitting via SERFF: You must include all rating business rules associated with all plan IDs for QHPs, on-Exchange SADPs, off-exchange SADPs, individual market plans, and SHOP market plans that you are submitting for QHP certification in one Business Rules Template and submit that template in all binders. If you submit more than one template through multiple different SERFF binders, each with different business rules, only the last template that your state transfers from SERFF to Centers for Medicare & Medicaid Services (CMS) will be retained; business rules data from all other binders within the same SERFF transmission will be overwritten. CMS requires submission of one single identical Business Rules template in all binders to avoid data overwrite problems.

If you are a dual issuer submitting the Business Rules Template via multiple SERFF binders, set *Medical, Dental, or Both?* to **Both** in all submitted Business Rules Templates. You may not enter **Medical** for this field in one template version and **Dental** for this field in another template version.

Complete the Business Rules Template using the steps outlined below. You cannot validate this template until all required fields are completed.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.

Business Rules Template	Steps
Medical, Dental, or Both?	Select one of the following from the dropdown menu: ◆ **Medical**—if entering rating business rules for medical plans only. ◆ **Dental**—if entering rating business rules for dental plans only. ◆ **Both**—if entering rating business rules for medical and dental plans within the template. You must enter a value for this field before proceeding. All other fields are locked until you respond to *Medical, Dental, or Both?*
Product ID	For products with rules that differ from those entered in row 10, enter the 10-character (12345AZ123) HIOS-generated product ID that identifies the product that will be associated with the rules defined in that row. ◆ If you enter a product ID, the rules defined in that row will be applied to all plans associated with that product ID. All other products will use the rules associated with either the HIOS Issuer ID in Row 10 or a different product ID rule. ◆ If you do not enter a product ID, the rules associated with the HIOS Issuer ID in Row 10 will be used.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (12345AZ1234567) that identifies the plan that will be associated with the rules in that row. ◆ If you enter a plan ID, the rules defined in that row will be applied to that plan ID only. All other products and plans will use the rules associated with the HIOS Issuer ID rule, product ID rule, or a different plan ID rule. ◆ If you do not enter a plan ID, the rules for the product ID associated with that plan ID will be used. If you also did not enter a product ID rule, the rules associated with the HIOS Issuer ID in Row 10 will be used.
Medical or Dental Rule?	Select whether the business rule in the template row applies to medical or dental plans. The dropdown options are: ◆ **Medical** ◆ **Dental**. The allowed value for this field depends on your response to *Medical, Dental, or Both?*: ◆ If you responded **Medical**, the issuer-level row (row 10) for *Medical or Dental Rule?* defaults to **Medical**. You may only enter **Medical** for any subsequent rule. ◆ If you responded **Dental**, the issuer-level row for *Medical or Dental Rule?* defaults to **Dental**. You may only enter **Dental** for any subsequent rule. ◆ If you responded **Both**, the issuer-level row for *Medical or Dental Rule?* defaults to **Medical**. You may enter **Medical** or **Dental** for any subsequent rule, and must have at least one medical rule and one dental rule within the template.
What is the maximum number of rated underage dependents on this policy?	Select the maximum number of rated underage dependents from the dropdown menu. A rated underage dependent is defined as age 0–20. A QHP cannot rate more than the three oldest covered children when determining the total family premium.[1] This rule does not apply to SADPs. The number of rated underage dependents is defined by the value entered for *Is there a maximum age for a dependent?* If you responded **Medical** for *Medical or Dental Rule*, the following are allowed: ◆ **1** ◆ **2** ◆ **3**. If you responded **Dental** for *Medical or Dental Rule*, the following are allowed: ◆ **1** ◆ **2** ◆ **3** ◆ **Not Applicable**.

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[1] 45 *Code of Federal Regulations* (CFR) 147.102(c)(1).

Business Rules Template	Steps
	Note: **Not Applicable** means that a dental plan associated with the business rule has no maximum number of rated underage dependents on a policy. This option is not available to medical plans.
Is there a maximum age for a dependent?	Set the maximum age for a dependent for purposes of eligibility. The maximum age for a dependent applies only to the dependent relationships of Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter. Choose from the following: ◆ **Yes**—if selected, a pop-up will allow you to enter the maximum age for a dependent. If you are a QHP issuer, you must enter a minimum value of 25 for a Medical business rule. If you are an SADP issuer, you must enter a minimum value of 18 for a Dental business rule. Note: The age entered is inclusive <u>through</u> that age. For example, if you enter a value of 25, you are offering to provide coverage 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 cover child dependents to make such coverage available for children until they attain age 26.[2] Note: Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 18.

How is age determined for rating and eligibility purposes?	Select how age is defined to determine if a consumer is eligible for a plan rate. Choose from the following:
	
	◆ **Age on effective date**—return the rate based on the consumer's age on the effective date. You must select this option for all QHP plans.
	
	◆ **Age on January 1 of the effective date year**—return the rate based on the consumer's age on January 1 of the effective date year.
	
	◆ **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 1 or July 1**—return the rate based on the following:
	    ▪ If the date of enrollment is before July 1, then use the age as of January 1.
	    ▪ If the date of enrollment is after July 1, then use the age as of July 1.
	
	Note: Market rules require QHP plans to select **Age on Effective Date**, whereas dental plans may choose from any of the four options above.[3]

How is tobacco status returned for subscribers and dependents?	Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following: ◆ **Applicable [x] months**—if selected, a pop-up will ask 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. SADP issuers are not subject to the look-back period.[4] 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 [x] months (tobacco rate) or not an active tobacco user within the last [x] 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, tobacco and non-tobacco use rates are not separate. If rates are calculated by adding up individual rates, 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 do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, tobacco rates are not applicable.

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[2] 45 CFR 147.120.

[3] 45 CFR 147.102(a)(I)(iii).

[4] 45 CFR 147.102(a)(I)(iv).

Business Rules Template	Steps
What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	◆ Select the relationships that are allowable 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 the primary subscriber or dependent. Choose from the following: ▪ Self (selected by default) ▪ Spouse ▪ Child ▪ Stepson or Stepdaughter ▪ Grandson or Granddaughter ▪ Brother or Sister ▪ Life Partner ▪ Nephew or Niece ▪ Collateral Dependent ▪ Ex-Spouse ▪ Foster Child ▪ Ward ▪ Sponsored Dependent ▪ Other Relationship ▪ Other Relative. ◆ For each relationship you select, indicate **Yes** or **No** whether the dependent is required to live in the same household: ▪ **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. ▪ Market rules require the entry of **No** for the household residency requirement for child dependents, for QHP products and plans that cover child relationships. This rule applies to Child, Foster Child, and Stepson or Stepdaughter relationships. ◆ Select **Life Partner** to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Relationships are not differentiated by sex. If a plan covers spouses and life partners, same-sex and opposite-sex spouses and life partners are covered.

See Figure 3B-1 for a sample completed Business Rules Template.

Figure 3B-1. Sample Business Rules Template

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

Template Validation	Steps
Validate Template	Click **Validate** 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.

Template Validation	Steps
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML file of the template that will need to be uploaded in the Business Rules section of the Rating Module in HIOS.
Save Template	**Save** the .XML template. We recommend that you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the saved .XML file in the Business Rules section of the Rating Module in HIOS. Refer to 3. Rating Module for details on how to complete this step.

After you enter all data, click **Save** to ensure no data are lost. Additional information on the Actuarial Value Calculator is included in Appendix A. See Appendix B for information on the plan ID. This completes the Instructions for the Rating Module section of the PY2022 QHP Application. The next section of the Instructions for the PY2022 QHP Application is the Supplemental Submission Module.

4. Supplemental Submission Module

The Plan Management Supplemental Submission Module (SSM) is a web application built within the Health Insurance Oversight System (HIOS) that allows issuers to submit and make URL data changes for their Qualified Health Plan (QHP) Applications. You do not need to submit a data change request or state authorization form to make URL changes in the SSM, but you must comply with all state regulations before changing URLs within the SSM. When you submit a URL change, you attest that all changes have been approved by your state.

The SSM consists of the Summary page and URL Data page. The Summary page (Figure 4-1) is the first page you will see when navigating to the SSM. Use it to view and update URL data at the issuer ID-level.

Figure 4-1. Supplemental Submission Module Summary Page

The URL Data page (Figure 4-2) is divided into three main sections: the Download Issuer URL Template File section, the Upload Issuer URL Template File section, and the Search & Update URLs section.

Figure 4-2. URL Data Page

Detailed instructions for using the SSM can be found on the Submissions Systems page on the QHP certification website.

Section 4A: URL Collection

1. Introduction

In the SSM, you can choose between two submission methods to submit or update previously submitted URL data: submit using a simple, pre-populated URL template, which you can download from the module, (recommended for your initial submission) or submit via a Search & Update capability available within the module's user interface.

> The instructions for this section apply to the following issuer types:
> - QHP
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Summary of Benefits and Coverage (SBC) URLs
3. Plan Brochure URLs
4. Enrollment Payment URLs
5. Network URLs
6. Formulary URLs
7. Transparency in Coverage URLs.

3. Quick Reference

Key Changes for 2022
◆ You are no longer required to submit a Transparency in Coverage Template before you submit a Transparency in Coverage URL. Once the SSM is open, you can submit Transparency in Coverage URLs with or without the template.

Tips for the URL Collection Section
◆ Verify that at least one Plans & Benefits Template was successfully submitted to the Benefits and Service Area Module in HIOS or transferred via the System for Electronic Rates and Forms Filing (SERFF) to ensure that the HIOS Issuer ID, issuer legal name, and state are present on the Summary page within the SSM.
◆ Verify that URLs are functional before you submit them.
◆ Transparency in Coverage URLs should be live when you submit them.
◆ All other URLs submitted via the SSM (SBC, Plan Brochure, Payment, Network, Formulary) should be submitted by the deadline for changing your QHP Application. All URLs must be active and directly route consumers to the appropriate document by the deadline for returning signed QHP agreements.
◆ Please note that while the URL requirements laid out here apply only to on-Exchange plans, off-Exchange URLs should still be submitted to the Rates and Benefits Information System.

Additional Resources
◆ There are no supporting documents for this section.
◆ There are no instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

The Summary page (Figure 4A-1) will display when you log into the SSM. Use the page filters to locate the HIOS Issuer ID you are submitting new or updated URLs for; your legal name and state will also display after you successfully submit at least one Plans & Benefits Template to the Benefits and Service Area Module in HIOS directly or via SERFF.

Figure 4A-1. Summary Page

After locating the appropriate HIOS Issuer ID, select **View** or **Edit** to be directed to the URL Data page. If the window for submitting and updating URL data is open, **Edit** will appear in the Action column. If the submission window is closed or a State Reviewer is accessing the SSM via the State Evaluation Module, **View** will appear in the Action column.

Use the three sections of the URL Data page—Download Issuer URL Template File, Upload Issuer URL Template File, and Search & Update URLs (Figure 4A-2)—to review and update URL data.

Figure 4A-2. URL Data Page

Use the Download Issuer URL Template File section to generate and download an Issuer URL Template File that contains all URLs currently associated with the selected HIOS Issuer ID. Transparency in Coverage, SBC, Plan Brochure, Payment, Network, and Formulary URLs can be included in the Issuer URL Template. You can select one or more URL types to download in a template or can select **All** to download a template populated with all six URL types. See Figure 4A-3 for an example of the Download Issuer URL Template File section with an Issuer URL Template File that has been generated for the issuer to download.

Figure 4A-3. Download Issuer URL Template File

The Issuer URL Template File provides details of the URLs currently associated with the selected HIOS Issuer ID and allows you to submit a large number of URL changes at once. To complete the template, enter values under *New URL* and save the template as a .CSV file. Then, upload the saved .CSV file in the Upload Issuer URL Template File section. See Figure 4A-4 for an example of an updated Issuer URL Template File.

Figure 4A-4. Issuer URL Template File

Use the Upload Issuer URL Template File section to submit URL updates by uploading a completed Issuer URL Template File. The system will validate that any Issuer URL Template File you upload is properly formatted and contains acceptable values. If an uploaded template has an error, the system will return an error message and may return a report outlining the validation error. You must correct any such errors and reupload the template. If a template passes all validations, the URL updates will be stored in the system. See Figure 4A-5 for an example of the Upload Issuer URL Template File section.

Figure 4A-5. Upload Issuer URL Template File Section

If you offer QHPs, you must submit Transparency in Coverage, Network, and SBC URLs. If you offer stand-alone dental plans (SADPs), you must submit Transparency in Coverage and Network URLs. You cannot upload any Network URLs until you submit a Transparency in Coverage URL.

Note: The Upload Issuer URL Template File section will return errors unless you submit all required URLs for each URL ID that is present in the SSM for that URL type. For example, if you submit one Network URL when there are two Network URL IDs in the SSM, the system will return an error because a required URL is missing.

Use the Search & Update URLs section to view existing URL data and make quick updates. To use the search function, enter search parameters by selecting a URL type in the drop-down menu and entering a URL ID and clicking the magnifying glass icon. You can enter a full or partial string of a URL ID to find a specific URL or leave the search field blank to return all URLs for the selected type (Figure 4A-6). URL updates you submit via the Search & Update URLs Section will undergo the same validations as the Issuer URL Template File.

Figure 4A-6. Search & Update URLs Section

URL Collection Process	Steps
Access the SSM	Log into the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal and select the HIOS application on the My Portal page.
	Within the HIOS portal, choose the **QHP Benefits and Service Area Module** and click **Launch this Module**.
	Within the **QHP Benefits and Service Area Module**, click **Access Supplemental Submission Module** on the bottom half of the landing page.
Find Issuer Information	On Summary page, use the page filters to locate the HIOS Issuer ID that requires URL updates and select **View** or **Edit** to be directed to the URL Data page.
Upload URL data into the SSM	In the Download Issuer URL Template File section of the URL Data page, choose the URL Types you intend to upload.
	Select **Generate Issuer URL Template**.
	Copy all new URL data into the Issuer URL Template File under *New URL* and save the template.
	Upload the completed Issuer URL Template File into the Upload Issuer URL Template File section of the URL Data page.
Updating previously submitted URL data	In the Upload Issuer URL Template File section of the URL Data page, enter search criteria, such as the URL type and relevant ID, to locate the previously submitted URL.
	Enter the updated URL under *New URL*.
	Click **Update** to submit all URL data updates.

After you enter all data, click **Submit** (if uploading the template) or **Update** (if uploading via the user interface) to ensure no data are lost. This completes the Instructions for the Supplemental Submission Module portion of the PY2022 QHP Application. The next section of the Instructions for the PY2022 QHP Application is the appendixes.

Appendixes

The appendixes contain additional or more detailed information on completing and submitting the QHP Application.

Appendix A: Actuarial Value Calculator (AVC)

Appendix B: Plan ID Crosswalk

Appendix C: Supporting Documents

Appendix D: Tools

Appendix E: Understanding Issuer Types

Appendix A. Actuarial Value Calculator (AVC)

1. Introduction

To satisfy the actuarial value (AV) requirements of 45 Code of Federal Regulations (CFR) 156.140 and 156.420, qualified health plan (QHP) issuers must use the AVC developed and made available by the Department of Health and Human Services (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. When you submit your QHP Application, HHS recalculates this value to validate that your plan designs meet AV requirements.[1] This section describes how cost-sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AVC.

2. Data Requirements

To complete this section, you will need the following:

1. Completed Plans & Benefits Template
2. Final standalone AVC.

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for Using the AVC
◆ If you are having difficulty matching AVs from the Plans & Benefits Template to the standalone AVC, follow the instructions on troubleshooting in Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template.
◆ The AVC has an Additional Notes field that outputs error messages that can only be seen in the standalone AVC. These notes are intended to help you understand the AVC's assumptions and to provide some information on the AV calculation being run in the AVC. When an AV calculation is not returned because of an input error, check the *Additional Notes* field for an explanation of the error.[2]
◆ 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.
◆ If 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).

Additional Resources
◆ Download the final 2022 Standalone AVC.
◆ There are no supporting documents for this section.
◆ There are no instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans, all silver plan cost-sharing reduction (CSR) variations, and all limited cost-sharing plan variations. The AVC cannot be used with catastrophic plans or stand-alone dental plans (SADPs). The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and does not run for the SADP Plans & Benefits

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

[2] These notes include things such as how the special cost-sharing provisions are being engaged in the calculations.

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 and the non-unique plan designs. If the standalone AVC returns an error for a unique plan design, resulting in a blank AV Calculator Output Number, you do not need to address the error to validate the template if your AV falls within the relevant de minimis range. We recommend you run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that your submissions include the AV Calculator Output Number for plans that do not generate an error in the standalone AVC. Table A-1 describes the steps involved when using the **Check AV Calc** procedure in the Plans & Benefits Template.

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

Check AV Calc		Steps
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 **Check AV Calc**. The **Check AV Calc** procedure will prompt you to select the file location of the standalone AVC. Use a clean copy of the AVC file that does not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and you will need to close all of the messages to finish the **Check AV Calc** procedure.
	Step 3	◆ A prompt will appear asking if you would like to save the screenshots. ◆ Select **Yes** if you wish to save screenshots. 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 you do not wish to save screenshots. The **Check AV Calc** procedure will complete without creating any new files.
	Step 4	A validation message box will appear with the status/error messages from the AVC for each plan or plan variation. The *AV Calculator Output Number* field (Column F in the Cost Share Variances worksheet) will be updated with the AV from the AVC. If an error prevented an AV from being calculated, *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, you must rerun the procedure so that the AVs in *AV Calculator Output Number* 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 you select should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all messages to finish the **Check AV Calc** procedure.
For Unique Plan Designs: Upload screenshot into HIOS.[3]	Step 7— (Optional)	◆ Copy the screenshots into a Word document (the Health Insurance Oversight System [HIOS] does not allow Excel files as supporting documents). ◆ Upload as a supporting document a screenshot of the standalone AVC with the **Plan Name**, **Plan ID**, and **HIOS Issuer ID** fields filled in, and include the plan ID (standard component) and date in the file name.

4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the application should include the Unique Plan Design—Supporting Documentation and Justification Form to certify that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and

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[3] You can use the standalone AVC to test plan designs, but you do not need to submit a completed standalone AVC or other supplemental documentation, such as a screenshot, except in scenarios described in Section 4.1 Unique Plan Design. Instead, you should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

state laws and actuarial standards of practice.[4] For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under 45 CFR 156.135(b), try to use the integrated version of the AVC before reverting to the use of the unique plan design option.

For plans compatible with the AVC, you must always use an actuarially justifiable process when inputting your plan designs into the AVC.[5] If the AV obtained from the template is not identical to the AV obtained from the standalone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in this appendix.

2. Follow the steps in Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template on troubleshooting the AVC.

3. After following the troubleshooting steps, determine whether you can replicate the results of the standalone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.

    a. If you cannot replicate the standalone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the standalone AVC and via the Plans & Benefits Template both fall within the relevant de minimis range for the plan's metal level or CSR variation, you do not need to designate the plan as a unique plan design. Instead, set the *Unique Plan Design* field to **No**, leave the *Issuer Actuarial Value* field blank, and run the integrated AVC.

    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 standalone AVC does, designate that particular plan as a unique plan design by setting the *Unique Plan Design* field to **Yes**. For this plan, complete the *Issuer Actuarial Value* field with the value from the standalone AVC. The AV from the standalone AVC must fall within the relevant de minimis range. Upload a screenshot of the standalone 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.

Note: There are certain cases in which you may not be able to match AVs between the Plans & Benefits Template and the AVC, such as in the following examples:

1. One or more benefits apply a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.[6]

2. One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but you do not wish to split the benefits into their component parts during the coinsurance phase. For instance, the X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components and the 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 benefits can be split into Outpatient Facility and Outpatient Professional components.

4.2 Differences between Standalone AV Calculator and Plans & Benefits Template

The screenshot feature allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the standalone AVC. When using the **Check AV Calc** procedure in the Plans & Benefits Template, select **Yes** after a prompt appears asking if you want to save the AVC screenshots, then select the location you want the screenshots to be saved. Once the **Check AV Calc** procedure has finished, you can open the folder and use the automatically generated screenshots to compare

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[4] When submitting a plan with a Unique Plan Design, consult state guidance and complete the Unique Plan Design—Supporting Documentation and Justification in accordance with the applicable state processes.

[5] For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on Actuarial Value.

[6] For more information, please refer to the AVC User Guide located in the first tab of the AVC.

with those manually created in the standalone AVC. This side-by-side comparison can be very helpful for determining if the cost-sharing structure has been entered and applied as intended.

Table A-2 describes the steps you should take to compare the AV generated by the **Check AV Calc** procedure and the AV generated by the standalone AVC.

Table A-2. Comparing Plans & Benefits and Standalone AVC Screenshots

Create and Compare Screenshots	
Step 1	Calculate the plan's AV in the standalone 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 line-by-line to identify the difference that 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 standalone AVC as shown in Figure A-1. However, if you entered the benefit cost sharing in the Plans & Benefits Template as shown in Figure A-2, the AV from the standalone AVC and the AV returned from **Check AV Calc** in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, you could open the screenshot file created by the **Check AV Calc** macro and the standalone AVC. Comparing the standalone AVC screenshot (Figure A-1) and the screenshot generated by the **Check AV Calc** macro in the Plans & Benefits Template (Figure A-3) would show that the *Subject to Deductible?* checkbox is checked in the Plans & Benefits Template screenshot, indicating that the copay is being applied with the deductible only in the Plans & Benefits Template. Resolve this discrepancy by referring to Table A-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 A-1. Standalone AVC Screenshot

Click Here for Important Instructions	Tier 1			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00

Figure A-2. Example Plans & Benefits Template 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 A-3. Screenshot Created by Check AV Calc

Click Here for Important Instructions	Tier 1			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00

5. Field Mapping

This section describes how the **Check AV Calc** procedure automatically maps data from the Plans & Benefits Template into the AVC. 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 with the order that the fields appear in the Plans & Benefits Template.

5.1 Metal Tier

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

Expanded Bronze Plans: The AVC includes an option for you to indicate that you are running an expanded bronze plan as finalized in the *HHS Notice of Benefit and Payment Parameters for 2018*. The expanded bronze plan option in the AVC allows you to calculate the AV for bronze plans that meet certain requirements, allowing you 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, non-preventive service 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) as established in 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. You must ensure your bronze plan meets these requirements if you use the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is −4 percentage points and +5 percentage points. Please see the AVC Methodology and the *HHS Notice of Benefit and Payment Parameters for 2018* 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, *Desired Metal Tier* depends on the AV level of the variation. *Desired Metal Tier* for silver plan variances is set to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation. *Desired Metal Tier* must be set to **Bronze** for expanded bronze plans.

De Minimis Range: In April 2017, we released a final rule, *Patient Protection and Affordable Care Act; Market Stabilization*, that amends the de minimis variation range for the AV level of coverage in 45 CFR 156.140(c). 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 now −4 percentage points and +2 percentage points. An 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.

5.2 Health Savings/Reimbursement Account Options

If **Yes** is entered in *HSA/HRA Employer Contribution* 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 A-4 shows the health savings account (HSA)/health reimbursement account (HRA) input fields in the Plans & Benefits Template and Figure A-5 shows the corresponding input fields in the AVC.

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

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$500.00

5.3 Tiered Network Options

The AVC can accommodate plans using up to two tiers of in-network services. You may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, maximum out-of-pocket (MOOP) costs, 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.[7]

If *Multiple In Network Tiers?* is set to **Yes** in the Cost Share 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 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 A-6 shows the tiered input fields in the Plans & Benefits Template, and Figure A-7 shows the corresponding input fields in the AVC.

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

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

Figure A-7. Multi-Tier Options in AVC

Tiered Network Option	
Tiered Network Plan?	☑
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the **Not Applicable** option, you can 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 MOOP, default coinsurance, and deductibles, but for simplicity it will not be noted in the individual sections that follow.

5.4 MOOP and Deductible Values

The AVC 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.

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

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 *In Network* is a dollar value (**$X**), *In Network* is used for the AVC.

2. If *In Network* is set to **Not Applicable** and *Combined In/Out of Network* is a dollar value (**$X**), *Combined In/Out of Network* is used for the AVC.

3. If the *In Network* and *Combined In/Out of Network* fields are set 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 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 set to **Not Applicable** and the *Combined In/Out of Network* field is 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. *In Network* is a dollar value, and *In Network (Tier 2)* is set to **Not Applicable**.

   b. *In Network* is set to **Not Applicable**, and *In Network (Tier 2)* is a dollar value.

   c. The *In Network*, *In Network (Tier 2)*, and *Combined In/Out of Network* fields are set to **Not Applicable**.

5.4.1 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 MOOP 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 MOOP* 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 MOOP* field in the AVC.

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

Figure A-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 A-9. Integrated Deductible, Coinsurance, 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 set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate MOOP 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* field 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* field 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 A-10 shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and Figure A-11 shows a corresponding example in the AVC.

Figure A-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 A-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	

2022 QHP Application Instructions

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds $9,300. 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 2022 AVC, the MOOP limit and related functions have been set at $9,300 to account for the proposed annual limitation on cost sharing for plan year 2022. The proposed 2022 annual limitation on cost sharing was specified in the proposed rule *HHS Notice of Benefit and Payment Parameters for 2022* (2022 Payment Notice) and is proposed to be $9,100 for self-only coverage and $18,200 for other than self-only coverage for 2022.[8] If you are required to meet AV standards, you must comply with the limit established in the regulation and may not use the projected estimates stated in the 2022 AVC 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 set to **No** and *Medical & Drug Deductibles Integrated?* is set to **Yes** in the Plans & Benefits Template, the Plans & Benefits Template returns an error when attempting to calculate the AV.

5.4.2 Deductibles

If you have a deductible greater than $0, one service must be subject to the deductible or the AVC will return an error.

If *Medical & Drug Deductibles Integrated?* is set 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.[9] The following applies to integrated deductibles:

1. The *Combined Medical & Drug 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 A-12 shows the integrated deductible fields in the Plans & Benefits Template. Figure A-9 displays a corresponding example in the AVC.

Figure A-12. Combined Medical and 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 *Medical & Drug Deductibles Integrated?* is set 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.

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[8] The final values in this section are subject to change upon finalization of the remaining policies in the proposed *2022 Payment Notice*.

[9] 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.

2. The *Drug EHB Deductible—In Network—Individual* <u>OR</u> *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* <u>OR</u> *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* <u>OR</u> *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.

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

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

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

5.5 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 you pay. Thus, the coinsurance values entered into the AVC must be set 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 you will incur. Table A-3 shows the mapping between the Plans & Benefits Template and the AVC and provides examples of coinsurance values in both.

Table A-3. Coinsurance Mapping between the Plans & Benefits Template and the AVC

Plans & Benefits (Enrollee's Cost Share)	AVC (Issuer'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 set 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* percent 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* percent 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 A-12 shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and Figure A-9 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 set 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* percent 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* percent 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* percent 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* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Drug Coinsurance* in the AVC.

5.6 Subject to 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 A-16 and Figure A-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 A-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 A-17. Benefit Categories in AVC

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

Table A-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/Behavioral Health and Substance Use Disorder benefits. For mental health and substance abuse benefits, see Table A-6. Section 5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services describes the copay and coinsurance mappings in more detail.

Table A-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 No Charge after deductible	X% X% Coinsurance after deductible	Checked	Checked	(1–X)%	Blank	Unchecked
No Charge Not Applicable	X% Coinsurance after deductible					
$X $X Copay per Day	X% Coinsurance after deductible	Checked	Checked	(1–X)%	$X	Unchecked

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

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
No Charge Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
$X $X Copay per Day $X Copay per Stay	No Charge Not Applicable	Unchecked	Unchecked	Blank	$X	Unchecked

5.7 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.

5.8 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, 1–X%, where X% 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, 1–X%, where X% 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.[10]

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.

5.9 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**, then 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**, then the *Tier 1 Copay, if separate* field in the AVC is set equal to

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[10] 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.

X. If *Copay—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable**, then 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 standalone AVC does not support applying both a copay and a coinsurance in the coinsurance range. If a benefit's copay is only after the 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 AVC 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 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 AVC also allows you to indicate the cost sharing for Primary Care and/or Specialist Office Visits and X-rays. The standalone AVC 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 AVC Methodology and User Guide.

5.10 Copay Applies Only After Deductible

For each benefit, if *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 *Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then 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. Although the standalone AVC returns an error if the *Copay applies 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.

5.11 Benefit Categories[11]

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

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 A-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 (including MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (excluding Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	

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[11] The 2021 AVC used new claims data from 2017 projected forward to 2021, and the 2022 AVC did not apply a trend factor from 2021 to 2022. For information about the considerations of the new claims data, please refer to the 2021 AVC Methodology.

Plans & Benefits Template Category Name	AVC Category Name
Substance Abuse Disorder Outpatient Services	Mental/Behavioral Health and 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[12]	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
Specialty Drugs	Specialty Drugs (high-cost)

5.11.1 Inpatient Hospital Services

If *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**, then 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, then 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 A-18 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template, and Figure A-19 shows the corresponding checkbox and field in the AVC.

If you intend to use the *Maximum Number of Days for Charging an Inpatient Copay?* feature when filling out the standalone AVC, you need to ensure that the *Apply Inpatient Copay per Day?* checkbox in the AVC (Figure A-20) is checked. Otherwise, the AVC will return an error when trying to calculate the AV. On the Plans & Benefits Template side, you need to follow the instruction in the first paragraph and select a cost-sharing

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[12] Section 2713 of the Public Health Service (PHS) Act, codified in 45 CFR 147.130, requires you to offer certain preventive care services without cost sharing, so the standalone AVC automatically takes into account no cost sharing for these services in the AV calculation and does not allow you 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 standalone AVC for this benefit category.

option that includes the text "per day" to ensure the *Apply Inpatient Copay per Day?* checkbox is checked in the AVC mapping.

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

Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5

Figure A-20. Apply IP Copay Checkbox in AVC

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver ▼

5.11.2 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**, then 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.

If you intend to charge a skilled nursing facility copay per day you should ensure you have selected the *Apply Skilled Nursing Facility Copay per Day?* checkbox while filling out the standalone AVC to ensure accuracy of AV calculations.

5.11.3 Primary Care

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, then 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 designed for primary care visits after the initial fully covered visits have occurred. You 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 *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, then 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. You 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 *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 A-21) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (Figure A-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 these options selected will trigger an error message.

Figure A-21. Primary Care Options in AVC

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
52	# Copays (1-10):	

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

If *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 Use Disorder Outpatient Services in the AVC is checked. Then, [0.8 × (Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1))] + [0.2 × (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 Use Disorder Outpatient Services in the AVC.

In the following two scenarios, [0.8 × (Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1))] + [0.2 × (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 Use Disorder Outpatient Services in the AVC:

1. *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **$X** or **$X with deductible** in the Plans & Benefits Template

2. *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 *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **$X after deductible** and *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, then the *Tier 1 Copay applies only after the deductible?* checkbox for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in Table A-5) 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**, then 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 Use 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**, then 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 Use Disorder Outpatient Services Tier 2 fields in the AVC.

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

Table A-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 Use Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
$X Copay after deductible No Charge after deductible	X% X% Coinsurance after deductible	Checked	Checked	1 − (80% Mental + 20% Substance)	Blank	Unchecked
No Charge 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% X% Coinsurance after deductible					
No Charge Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge Not Applicable No Charge after deductible					
$X Copay after deductible	No Charge Not Applicable	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked

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

5.11.5 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.

5.11.5.1 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 A-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 A-22) cannot vary between Tier 1 and Tier 2.

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

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$200

6. Zero Cost-Sharing and Limited Cost-Sharing Plan Variations

Zero cost-sharing plan variations, which are required to have zero cost sharing for all Essential Health Benefit (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 via 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 B. Plan ID Crosswalk

1. Introduction

The Plan ID Crosswalk Template crosswalks plan year (PY) 2021 qualified health plan (QHP) plan ID and service area combinations to a PY2022 QHP plan ID. These data facilitate 834 enrollment transactions from the Centers for Medicare & Medicaid Services (CMS) for enrollees in the Individual market who did not actively select a different QHP during Open Enrollment. These instructions apply to QHP and stand-alone dental plan (SADP) issuers that offered Individual market plans on the Exchange during PY2021.

> The instructions for this section are the same for the following issuer types:
> - HIOS
> - SERFF
> - SADP
>
> See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer's state
3. Market coverage
4. Completed Plans & Benefits Template
5. Completed Service Area Template.

3. Quick Reference

Key Changes for 2022
◆ No changes for the 2022 QHP Application.

Tips for the Plan ID Crosswalk Section
◆ If you are submitting a QHP for the first time, you are not expected to submit a Plan ID Crosswalk Template.
◆ We have deferred the Federally-facilitated Small Business Health Options Program's (FF-SHOP's) ability to auto-renew employees for PY2022. Do not submit a Plan ID Crosswalk Template for FF-SHOP plans.
◆ Submit the Plan ID Crosswalk Template via the Plan Management (PM) Community.
◆ Import only one Plans & Benefits Template and one Service Area Template. Submit separate templates for SADPs.

Additional Resources
◆ There are supporting documents for this section.
◆ There are instructional videos relating to this section.
◆ There are templates for this section.

4. Detailed Section Instructions

You must submit evidence that your state has authorized you to submit your Plan ID Crosswalk Template no later than June 16, 2021. Provide evidence of state authorization, such as an email confirmation, via the PM Community.

States can review the Plan ID Crosswalk Template for compliance with Patient Protection and Affordable Care Act (PPACA) market reforms and will individually determine how they will review the Plan ID Crosswalk Template. For example, a state might review to confirm that the submitted Plan ID Crosswalk Template is consistent with state and federal requirements and matches the expectations of its form filing reviews.

We do not send Plan ID Crosswalk Templates to states, but your state regulators may ask you to provide this template in addition to your QHP Application (as part of the National Association of Insurance Commissioners' [NAIC's] System for Electronic Rates and Forms Filing [SERFF] binder, for example).

If you are in a direct enforcement state (Missouri, Oklahoma, Texas, and Wyoming), submit the authorization form to your state's Department of Insurance and to CMS's Compliance and Enforcement Division (formfiling@cms.hhs.gov) to obtain the necessary authorization for submission.

The following steps outline how to complete the Plan ID Crosswalk Template, beginning with the **2021 Plan Crosswalk** tab in the table below.

2021 Plan Crosswalk Tab	Steps
Import 2021 Plans & Benefits and Service Area Template	Click **Import 2021 Plans & Benefits and Service Area Template** to import the completed templates. The template will prompt you to select your completed 2021 Plans & Benefits and Service Area Templates. Before importing these templates, save them in the same folder; both must be uploaded at the same time. To select both files, click one template, then press and hold **Ctrl** on Windows or **Cmd** on macOS while clicking on the other template, and then click **Open**. Select exactly one of each type of template. The Plan ID Crosswalk Template will populate a list of PY2021 plan IDs and their associated service areas on the 2021 Plan and Service Area Data tab. Review this tab to ensure the data were accurately imported. After the PY2021 plan and service area data have been imported, the 2021 **Plan Crosswalk** tab will be populated with all applicable issuer information as well as a row for each PY2021 plan ID.
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 where you are offering coverage.
Market Coverage	Ensure the template has accurately populated the market coverage from the drop-down menu. The FF-SHOP Exchange will not allow auto-renewals for PY2022, so this field will be hard coded to **Individual**.
Dental Only	Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental-only plans. Choose from the following: ◆ **Yes**—this template is for SADPs only. ◆ **No**—this template is for QHPs.
Crosswalk Level	Select the level at which you would like to crosswalk each PY2021 plan from the drop-down menu. Choose from the following: ◆ **Crosswalking to the Same Plan ID:** Select this option if you are crosswalking your PY2021 plan to the same plan ID for PY2022, 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 PY2022 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 PY2021 plan to two or more PY2022 plan IDs. Note: If your PY2021 plan covered the entire state, you will need to crosswalk the plan for every county in the state. ◆ **Crosswalking at the ZIP Code level for one or more counties:** Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2021 plan to two or more PY2022 plan IDs for the same county. Selecting this option will require you to select the counties from the PY2021 plan's service area that will be crosswalked at the ZIP Code level. The remaining PY2021 service area will be crosswalked at the county level. Note: Do not crosswalk at the ZIP Code level unless absolutely necessary. ◆ **Discontinue with no crosswalk:** Select this option if you are discontinuing a PY2021 plan with no re-enrollment option for its enrollees. ◆ **Plan withdrawn prior to certification:** Select this option if the PY2021 plan was withdrawn from the Exchange before certification and has no enrollment. You should also select this option if the PY2021 plan ID listed on the template was not approved by the state or the Federally-facilitated Exchange (FFE) to be offered on the Exchange in PY2021.

2021 Plan Crosswalk Tab	Steps
Counties Crosswalked at ZIP Code Level	Select the counties in your PY2021 plan's service area that will be crosswalked at the ZIP Code level from the pop-up menu.

To complete the information on the **2022 Plan Crosswalk** tab, follow the steps in the table below.

2022 Plan Crosswalk Tab	Steps
Create "2022 Crosswalk Tab"	Click **Create "2022 Crosswalk Tab."** This action creates one 2022 Plan Crosswalk tab. The first four columns, 2021 HIOS Plan ID, County Name, Service Area ZIP Codes, and Crosswalk Level, will be auto-populated based on your entries in the 2021 Plan Crosswalk tab. If you decide to crosswalk at the plan ID-county level for one or more plans, a row will appear for each county that plan covered in PY2021. If you decided to crosswalk at the ZIP Code level for specific counties covered by a PY2021 plan, a row for each Plan ID-County-ZIP Code combination will appear. Only click **Create "2022 Crosswalk Tab"** when you are sure the 2021 Plan Crosswalk tab is complete. You cannot change a 2022 Plan Crosswalk tab after it is created. Instead, you will need to click **Create "2022 Crosswalk Tab"** again to clear all data and start over on the 2022 Plan Crosswalk tab. You can copy and paste your previously entered information into a separate workbook if you want to save your previous work.
Crosswalk Reason	Choose the reason for the crosswalk from the drop-down menu. Certain options will only be available for specific crosswalk levels. Table B-1 details crosswalk reason entries for each crosswalk level: ◆ **Renewing exact same product/plan combination (Same PY2021 Plan ID):** Select this option if you are crosswalking this plan ID/service area to the exact same HIOS plan ID. The template will auto-populate the **PY2022 Plan ID** field with your PY2021 plan ID. Use the same HIOS plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2022 plan year. You must comply with the "same plan" standards as defined in 45 Code of Federal Regulations (CFR) 144.103. ◆ **Renewing exact same product/plan combination (Different 2022 Plan ID):** Select this option if you are crosswalking this plan ID/service area to the same product/plan combination but with a different PY2022 plan ID. If possible, you should use the same HIOS plan ID if the same plan ID/service area combination was available the previous year and remains available. If you are continuing a plan, but wish to crosswalk to a different HIOS plan ID, you must obtain approval from your state regulatory authority before you submit your Plan ID Crosswalk Template. You must comply with the "same plan" standards as defined in 45 CFR 144.103. ◆ **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 on the FFE. If you select this option, you must use the same product ID embedded in the plan's 2021 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 PY2022 but will no longer offer any plans in part of the service area covered by the product in PY2021 and are crosswalking to a plan within a different product offered on the FFE. Select this reason for the portion of the service area where you no longer offer any plans under that product. If you select this option, you must crosswalk to a PY2022 plan ID with a different product ID from the PY2021 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 PY2021 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Do not enroll such plans into a plan offered off the Exchange. Selecting this option will disable the *2022 HIOS Plan ID* field.

2022 Plan Crosswalk Tab	Steps
	◆ **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 PY2021 product is discontinued for PY2022 and enrollees in this plan and associated service area will be re-enrolled in a plan under a different product offered on the FFE. The entered PY2022 plan ID must have a different product ID, and you may not enter the discontinued PY2021 product ID for any other row under the PY2022 plan ID. Crosswalk any discontinued PY2021 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if you do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, we will crosswalk the discontinued plan to another product you offer under the same HIOS Issuer ID. ◆ **Discontinuing product: no enrollment option:** Select this option if a PY2021 product is discontinued for PY2022 and there is no enrollment option on the FFE for PY2021 enrollees in this plan ID/service area combination. Do not enroll pertinent plans into a plan offered off the Exchange. Selecting this option will disable the *PY2022 Plan ID* field. Under this option, you may not enter the discontinued PY2021 product ID for any other row under the PY2022 plan ID. You should crosswalk any discontinued PY2021 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if you do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, we will crosswalk the discontinued plan to another product you offer under the same HIOS Issuer ID.
2022 HIOS Plan ID	Enter the PY2022 plan ID you would like to crosswalk your enrollees to for the row's PY2021 plan ID/service area. This field will be auto-populated when **Renewing exact same product/plan combination (Same 2021 Plan ID)** is chosen under *Crosswalk Reason*. This field will be disabled when **Discontinuing product; no enrollment option** or **Continuing product; no plan available in the particular service area under that product; no enrollment option** are chosen under *Crosswalk Reason*. Note: Only enter PY2022 plan IDs for plans that will be offered on the Exchange and are listed in the 2022 QHP Application. We will not accept any PY2022 plan IDs for plans only sold off the Exchange.
Is this PY2022 Plan a Catastrophic or Child-Only Plan?	This field will default to **No**. Please select **Yes** if you are crosswalking a catastrophic or child-only plan.
PY2022 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan	If you respond **Yes** to *Is this PY2022 Plan a Catastrophic or Child-Only Plan?*, this field will allow you to enter a PY2022 plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2022 plan ID entered in this field.
Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s)	Complete the following optional data fields if directed to do so by your state regulator: ◆ **PY2021 Plan ID**—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ **PY2022 Plan ID**—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ **PY2022/21 Plan ID** (catastrophic or child-only)—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings.

See Figure B-1 for a sample completed Plan ID Crosswalk Template.

Figure B-1. Sample Plan ID Crosswalk Template

Table B-1 lists the crosswalk reason and PY2022 plan ID entry options for each crosswalk level.

Table B-1. Crosswalk Level, Reason for Crosswalk, and PY2022 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2022 HIOS Plan ID
Crosswalking to same plan ID	Renewing exact same product/plan combination (auto-populated) (same PY2021 plan ID)	Template auto-populates field with PY2021 plan ID.
Crosswalking at the plan ID level	Renewing exact same product/plan combination (different PY2022 plan ID)	Different plan ID.
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2021 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 PY2021 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 PY2022 plan ID.
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2021 plan ID.
Crosswalking at the plan ID and county coverage level	Renewing exact same product/plan combination (same PY2021 plan ID)	Template auto-populates field with PY2021 plan ID.
	Renewing exact same product/plan combination. (different PY2022 plan ID)	Different plan ID.
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2021 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 PY2021 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 PY2022 plan ID.
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2021 plan ID.

2022 QHP Application Instructions

Crosswalk Level	Crosswalk Reason	2022 HIOS Plan ID
	Discontinuing product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
Crosswalking at the ZIP Code level for one or more counties	Renewing exact same product/plan combination (same PY2021 plan ID)	Template populates field with PY2021 plan ID.
	Renewing exact same product/plan combination (different PY2022 plan ID)	Different plan ID.
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2021 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 PY2021 plan ID.
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
	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 PY2022 plan ID.
	Discontinuing product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2021 plan ID.
Discontinue with no crosswalk	Discontinuing product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.
Plan withdrawn prior to certification	Plan withdrawn prior to certification; no enrollment option	*PY2022 HIOS Plan ID* field is disabled.

Once the Plan ID Crosswalk Template is completed, you must validate, finalize, and upload the files to the PM Community.

Template Validation	Steps
Validate Template	Click **Validate** on the **2021 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 reason for and cell location of each error. Correct any identified errors, and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** on the 2021 Plan Crosswalk tab to create the .XML version of the template you will upload in the PM Community.
Save Template	**Save** the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Enter the subject title "2021 Plan ID Crosswalk," then click **Submit Template** to upload the finalized template to the PM Community. Note: If you modify the .XML file name after finalization, we cannot process the template.

5. Submitting Plan ID Crosswalk Documents

You must submit your Plan ID Crosswalk templates and associated documents via the PM Community.

Follow these steps to upload and submit the .XML version of the Plan ID Crosswalk Template, your required state authorization, and any justifications, if applicable:
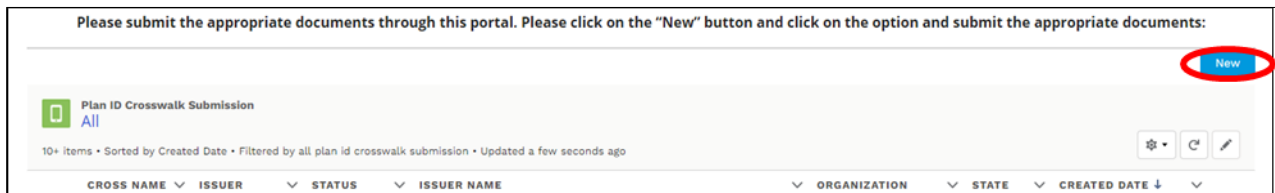
1. Log in to the PM Community and select **Plan ID Crosswalk Submission** from the top bar, as shown in Figure B-2.

Figure B-2. PM Community Home Screen

2. On the Plan ID Crosswalk Submission tab, click **New** on the right of the screen (Figure B-3).

Figure B-3. Plan ID Crosswalk Submission Page

3. In the pop-up, the Create Crosswalk Template Issuer Selection Window, use the drop-down menu in the search bar to select the specific HIOS Issuer ID and the plan year for which you are uploading a crosswalk. For example, for HIOS Issuer ID **12345** and plan year **2022**, select **12345-2022**. Complete this process for each HIOS Issuer ID for which a Plan ID Crosswalk Template is being submitted. After you select a specific HIOS Issuer ID, click **Next** on the right of the screen (Figure B-4).

Figure B-4. Create Crosswalk Template Issuer Selection Window
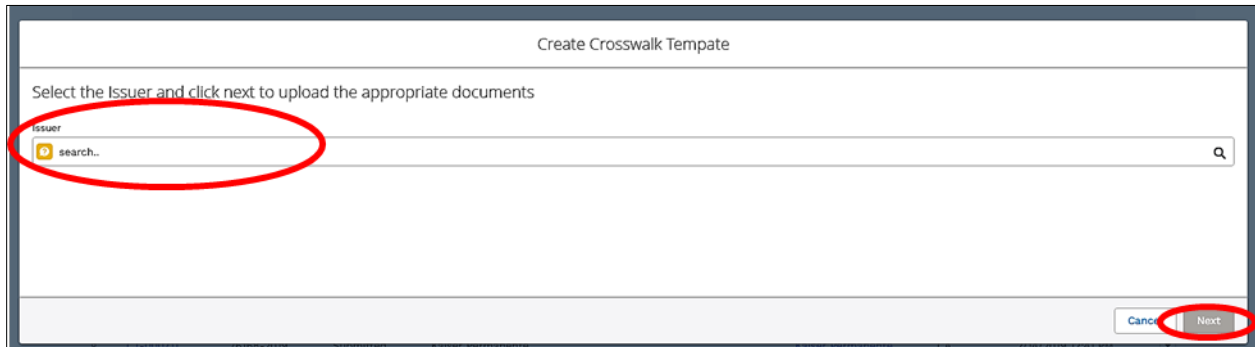
4. In the next pop-up, the Create Crosswalk Template File Upload Window (Figure B-5), upload the following three file types:

   a. Crosswalk Template. Submit this template during the certification window in .XML format. No other file formats will be accepted. This file is created after you validate and finalize the Excel-based Plan ID Crosswalk Template.

   b. State Authorization. Submit this file during the certification window in MS Word or PDF format. The file allows states to attest that they have seen and approved of your proposed plan crosswalks.

c. Justification. This file is optional and may be submitted in MS Word or PDF formats. If you have data issues or variances from the required regulations in your template, you may upload a justification file explaining why you believe your crosswalk is in compliance.

If you have multiple templates, state authorizations, or justifications for a single HIOS Issuer ID, you may upload all files at one time.

Figure B-5. Create Crosswalk Template File Upload Window
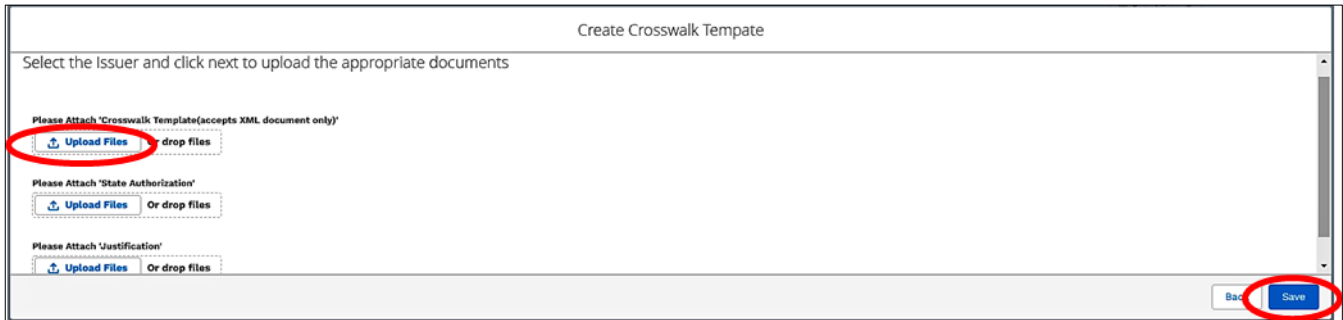
5. After uploading these files, you will see the Upload Files screen shown in Figure B-6. Click **Done** to continue.

Figure B-6. Upload Files Confirmation
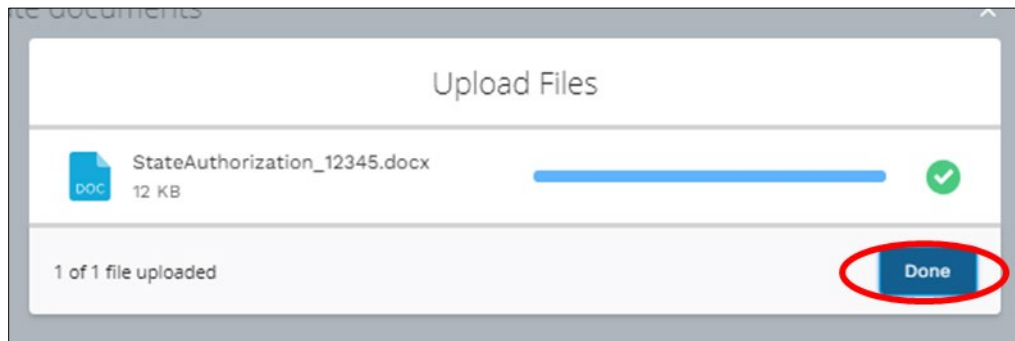
6. The uploaded file names will appear on the Create Crosswalk Template window (see Figure B-7).

Figure B-7. Create Crosswalk Template File Upload Window after Upload
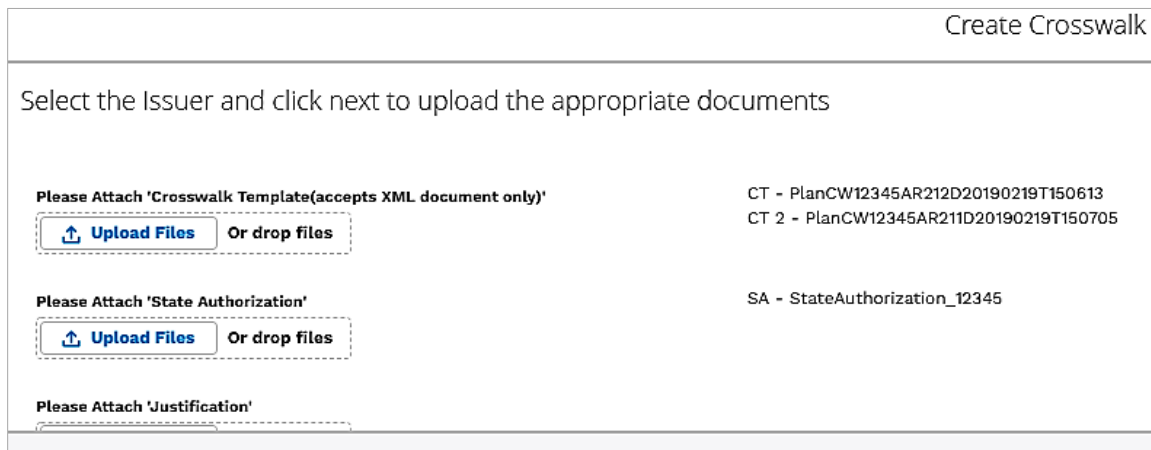
7. After you've uploaded all required files, click **Save** in the bottom right of the window (see Figure B-5).

8. After saving, the template will load the Plan ID Crosswalk Submission Window page (see Figure B-8). Click **Submit Templates** in the top right of the screen to submit your templates.

   WARNING**:** If you upload or save files but do not click **Submit Templates**, we will not receive the files.

Figure B-8. Plan ID Crosswalk Submission Window

9. Figure B-9 shows a closer view of the left side of Figure B-8. The status says New, indicating that the files have not yet been submitted. After you click **Submit Templates**, the status will change to Submitted, as shown in Figure B-10 to indicate that all files have been transferred to us and the crosswalk upload process is complete.

Figure B-9. Screen before "Submit Templates" Is Clicked

Figure B-10. Screen after "Submit Templates" Is Clicked

To update your Plan ID Crosswalk Template or State Authorization or to submit a new justification document, repeat this Plan ID Crosswalk submission process.

Appendix C. Supporting Documentation

You may be asked to submit supporting documentation and justifications as part of the Qualified Health Plan (QHP) Application process.

Note: Not all QHP Application sections require you to submit supporting documentation or justifications.

Table C-1 lists the supporting documentation and justifications for each application section. It describes the files, the criteria that determine whether you must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention you need to use when naming the supporting documentation or justification.

Table C-1. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
State Partnership Exchange (SPE) Issuer Program Attestation Response Form	Provides your attestations if your state performs plan management functions and you are not able to respond to attestations via the Health Insurance Oversight System (HIOS).	Required only if your state performs plan management functions (see Section 1A: Program Attestations).	Attestations	[Issuer ID]_SPEissuer Attestations
Interoperability Attestation and Justification Form	Documents your attestation of compliance with new Interoperability requirements.	Required for Medical QHPs in the FFE. This form is not required for FF-SHOP, SBE-FP, or SADP issuers.	Attestations	[Issuer ID]_InteroperabilityAttestation.pdf
Compliance Plan	Documents that your compliance plan adheres to all applicable laws, regulations, and guidance; that the compliance plan is ready for implementation; and that you agree to reasonably adhere to the compliance plan you've provided.	Required if you respond **Yes** to *Optional Attestations* (see Section 1A: Program Attestations).	Attestations	[Issuer ID]_Compliance PlanandCoverSheet.pdf
QHP Compliance Plan and Organizational Chart Cover Sheet	Accompanies your compliance plan to identify the page numbers where the required compliance plan elements are found.	Required if you respond **Yes** to *Optional Attestations* (see Section 1A: Program Attestations).	Attestations	[Issuer ID]_Compliance PlanandCoverSheet.pdf

Title	Description	Submission Criteria	Section	Suggested File Name
Organizational Chart	Documents your organizational chart.	Required if you respond **Yes** to *Attestations required of both Medical QHP and SADP issuers* (see Section 1A: Program Attestations).	Attestations	[Issuer ID]_Organizational Chart.doc
Optional Program Attestation Justification for the Federally-facilitated Exchange	Describes why you are not submitting a compliance plan.	Required if you respond **No** to *Optional Attestations* (see Section 1A: Program Attestations).	Attestations	[Issuer ID]_Compliance JustificationForm
Licensure Documentation	Demonstrates that you are licensed.	Required if you respond **Yes** to questions 1 or 2 [see Section 1B: State Licensure (Optional)]. Note: Required only if you choose to complete the Licensure section.	State Licensure	[Issuer ID]_Certificateof Compliance, or [Issuer ID]_COA or [Issuer ID]_StateLicense
Good Standing Supplemental Response	Describes how you intend to comply with state solvency standards and explains any noncompliance that has caused financial insolvency.	Required if you respond **Yes** to question 1 [see Section 1C: Good Standing (Optional)]. Note: Required only if you choose to complete the Good Standing section.	Good Standing	[Issuer ID]_GoodStanding SupplementalResponse
Corrective Action Plan	Describes how you intend to respond to corrective actions and explains how the corrective action plan or equivalent document will address the issues identified by the state.	Required if you respond **Yes** to question 2 [see Section 1C: Good Standing (Optional)]. Note: Required only if you choose to complete the Good Standing section.	Good Standing	[Issuer ID]_Corrective ActionPlan
Accreditation Certificate	Demonstrates that you are accredited.	You may choose to submit this certificate if you are accredited.	Accreditation	[Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes an implementation plan and payment structure that provides increased reimbursement or other market-based incentives to improve plan enrollee health outcomes.	Required if you have issued QHPs on an Exchange for two or more consecutive years that offer family or adult-only medical coverage and meet the QIS minimum enrollment threshold in the individual market or Small	Access the QIS Guidance and QIS Implementation Plan and Progress Report form on the [Data Collection Guideline page](#) of the Centers for Medicare & Medicaid Services (CMS) website.	[Issuer ID]_[Issuer Name]_QIS If submitting more than one QIS: [Issuer ID]_[Issuer Name]_QIS_[#]

Title	Description	Submission Criteria	Section	Suggested File Name
		Business Health Options Program (SHOP) Exchange. Review the QIS threshold in the QIS Technical Guidance and User Guide for the 2021 Plan Year.		
Supplementary Response: Inclusion of Essential Community Providers	Describes why you cannot meet the Essential Community Provider (ECP) requirements. Justifications for medical ECPs and dental ECPs have different requirements.	Required for medical ECPs if your plan network does not include at least 20 percent of available ECPs in the service area, does not offer a contract to all Indian health care providers in the service area, and does not offer a contract to at least one ECP in each available ECP category in each county in the service area. Required for dental ECPs if your plan network does not include at least 20 percent of available ECPs in the service area and does not offer a contract to all Indian health care providers in the service area.	ECP/Network Adequacy	[Issuer ID]_ECP_ supplemental_response Dual-product issuers should submit two files with the following naming conventions: ◆ [Issuer ID]_ECP_ supplemental_ response_QHP ◆ [Issuer ID]_ECP_ supplemental_ response_SADP
Network Adequacy Access Plan and Cover Sheet	A Cover Sheet and Access Plan that address the 11 areas in the Supporting Documentation table in Section 1E: Essential Community Providers/Network Adequacy. Submit the Cover Sheet as the first page of the Access Plan.	We will notify you by email if you need to submit access plans for any of your QHPs or stand-alone dental plans (SADPs).	ECP/Network Adequacy	[Issuer ID]_Access_Plan (may include Cover Sheet if it is included as part of the Access Plan) [Issuer ID]_Access_Plan_ Cover_Sheet (if Cover Sheet is submitted as a separate document)
Service Area Partial County Supplemental Response	Describes why you cannot serve an entire county.	Required if you request to serve only part of a county in a service area.	Service Area	[Issuer ID]_[State Abbreviation]_service_ area_partial_county

Title	Description	Submission Criteria	Section	Suggested File Name
Combined Prescription Drug Supporting Documentation and Justification	Explains why a correction was required in the Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count and how each is not discriminatory.	Required if we issue a correction in the Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ combineddrug
Discrimination—Treatment Protocol Supporting Documentation and Justification	Explains why a drug list's outlying out-of-pocket cost is not discriminatory.	Required if we determine the out-of-pocket cost is an outlier.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ treatmentprotocol
Discrimination—Language: Supporting Documentation and Justification	Explains why language identified as discriminatory is not.	Required if we determine language is discriminatory.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ discrimination_language
Discrimination—Cost-Sharing Outlier: Supporting Documentation and Justification	Explains why outlying cost-sharing values should be allowed and are not discriminatory.	Required if we determine cost-sharing values are outliers at the national or state levels and you do not correct them. States determine the System for Electronic Rates and Forms Filing (SERFF) submission requirements.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ discrimination_cost_ sharing
Unique Plan Design—Supporting Documentation and Justification	Describes why a plan qualifies as unique (why it is incompatible with the standard Actuarial Value Calculator [AVC]) and the methods used to calculate AV.	Required if you respond **Yes** to *Unique Plan Design?*	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ unique_plan_design
Silver/Gold: Supporting Documentation and Justification	Explains why a plan does not meet silver/ gold requirements.	Required if your plan fails silver/gold review.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_silvergold
Stand-Alone Dental Plan Actuarial Value Supporting Documentation	Describes the methods used to calculate AV and notes the certified AV level of pediatric Essential Health Benefits (EHBs).	Required if you issue an SADP.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_SADP_ actuarial_value

Title	Description	Submission Criteria	Section	Suggested File Name
Stand-Alone Dental Plan—Description of EHB Allocation Supporting Documentation and Justification	Details the methods and specific analysis used to determine the EHB apportionment for pediatric dental.	Required if you issue an SADP.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ description_EHB_ allocation
EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification	Describes EHB compliance for issuers that opt to substitute benefits for EHBs.	You may submit this form or an alternative form to demonstrate EHB compliance. SERFF issuers are not required to submit this form.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_EHB_ actuarial_equivalent

Saving Supporting Documents

Save supporting documentation and justifications using the file-naming conventions in the last column of Table C-1. A period, a hyphen, and an underscore are the only special characters you may use for a file name; do not include spaces. The file name may include lowercase and uppercase letters. Its full path length must not exceed 255 characters if the file is being uploaded to HIOS. When uploading supporting documentation and justifications, use only the following document formats:

Valid Supporting Document Formats	
.doc	.docx
.jpg	.jpeg
.rtf	.pdf
.ppt	.pptx
.csv	.txt

Uploading Supporting Documents

When multiple plans in an application section use the same supporting documentation or justification reasoning, list all of the supported products and plans in the same uploaded document.

Appendix D. Review Tools

Run each of these tools, as applicable to your issuer type (stand-alone dental plan [SADP] or qualified health plan [QHP]), to identify and correct data errors before uploading materials to the Health Insurance Oversight System (HIOS) or the System for Electronic Rates and Forms Filing (SERFF). Table D-1 provides a high-level description of each tool's functionality.

Table D-1. 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 to reduce 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 Federally-Facilitated Exchange (FFE) plans that were offered in 2021 are included in the crosswalk, the plans are crosswalked to valid 2022 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, Essential Community Provider (ECP)/Network Adequacy, and Prescription Drug Templates and serves as a data input file to the other standalone tools.
Essential Community Providers Tool for QHPs	Calculates the total number of medical ECPs an issuer has in each plan's network and compares this to the number of available medical ECPs in that service area. This tool checks 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.
Essential Community Providers Tool* for SADPs	Calculates the total number of dental ECPs an issuer has in each plan's network and compares this to the number of available dental ECPs in that service area. This tool checks 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.
Non-Discrimination Tool	Performs an outlier analysis for *QHP Discriminatory Benefit Design* as discussed in the draft 2022 Letter to Issuers. This tool looks at all plans in the state, goes through a group of predetermined benefits, and determines whether 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 four different checks (when they are applicable to the plan) for cost-sharing standards. This includes Maximum Out of Pocket (MOOP) Cost Review, Cost-Sharing Reduction (CSR) Plan Variation Review, Expanded Bronze Plan Review, and Catastrophic Plan Review.
Category & Class Drug Count Tool	Compares the count of unique chemically distinct drugs in each United States Pharmacopeia (USP) v8 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 or step therapy requirements in 28 USP classes.
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with certain conditions as recommended in clinical guidelines to ensure that issuers are offering sufficient types and numbers of drugs.

* Indicates tools that apply to SADP issuers.

Appendix E. Understanding Issuer Types

You will need to differentiate your QHP Application based on if you offer Medical QHPs or SADPs. Each section of this document indicates the type of issuers to which the information applies in a callout box, as shown in Figure E-1.

Figure E-1. Example Identification Box

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix E for additional information.

Table E-1 identifies how we categorize issuer types for this document.

Table E-1. Terms and Descriptions

Term	Description
QHP	Qualified health plan. As defined in Section 1301(a) of the Patient Protection and Affordable Care Act (PPACA), a QHP is an insurance plan that is certified by the Health Insurance Marketplace, provides Essential Health Benefits, follows established limits on cost sharing, and meets other requirements outlined within the application process.
SADP	Stand-alone dental plan. As defined in Section 1302(b)(1)(J) and Section 1311(b)(2)(B)(ii) of the PPACA, a SADP is an insurance plan that only provides limited scope dental benefits. SADPs provide dental benefits that are offered in a separate plan and are generally considered to be "excepted benefits" with varying applicable statutory and regulatory standards that differ from QHPs. SADPs are excepted from the insurance market reform provisions of the Public Health Service Act and the PPACA, including but not limited to: medical loss ratio standards; rating standards related to age, family size, rating area, and tobacco use; and guaranteed availability and guaranteed renewability standards.