

Qualified Health Plan Issuer Application Instructions

Plan Year 2024

**Extracted section:
Section 2H: Prescription Drug**

Section 2H: Prescription Drug

1. Introduction

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

The instructions for this section apply to the following issuer type:

- QHP

See Appendix E for additional information.

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 2024

- ◆ For Standardized Plan Options (SPOs), issuers should have four tiers of prescription drug cost sharing. The cost sharing should conform with the following benefits specified in the Final HHS Notice of Benefit and Payment Parameters for 2024: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. If you include the Zero Cost Share Preventive Drugs tier type, that tier type must be entered as Tier 1 for the associated formulary ID within the Prescription Drug Template. If you include the Medical Service Drugs tier type, that tier type must be entered as the highest tier for the associated formulary ID within the Prescription Drug Template. Finally, if you include both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types in their standardized plan options, you should enter Zero Cost Preventive Drugs for Tier 1, Generic Drugs for Tier 2, Preferred Brand Drugs for Tier 3, Non-preferred Drugs for Tier 4, Specialty Drugs for Tier 5, and Medical Services Drugs for Tier 6.
- ◆ The template will now allow you to enter a duplicate instance of an RXCUI on the *Drug Lists* tab. Each RXCUI you choose to duplicate may only be duplicated once in the template. If you offer one drug list, the one instance of the duplicate RXCUI must be assigned to a tier that corresponds to the Zero Cost Share Preventive Drugs tier type on the *Formulary Tiers* tab. If you offer more than one drug list, you may enter values of “NA” for both instances of the RXCUI, denoting the RXCUI is not covered on that drug list, or you may enter the value of “NA” for one instance of the duplicate RXCUI and may assign the second instance of the duplicate RXCUI to any other tier.
- ◆ SPOs of different metal levels must have distinct formulary IDs selected to ensure the appropriate cost sharing is assigned for that plan’s level of coverage.

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 MPMS includes only the Number of Tiers and Drug Tier Type fields for the first formulary associated with each drug list.
- ◆ If you offer plans in the Individual and SHOP Markets, you must create separate formulary IDs for each market, regardless of whether the formulary is intended to serve both markets. If you submit via the National Association of Insurance Commissioners’ (NAIC’s) System for Electronic Rates & Forms Filing (SERFF) you must use the same Prescription Drug Template across all binders or ensure that no formulary IDs repeat across the binders.

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.

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 2H-1 for a sample completed Drug Lists worksheet.

Figure 2H-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	<p>When selecting RXCUIs to include, use the December 5, 2022, 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.</p> <p>Application resources including the EHB RX Crosswalk, a reformatted RxNorm database, and state review tools can be found on the Review Tools page of the qualified health plan (QHP) certification website.</p> <p>RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK.</p> <p>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.”</p>
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	<p>Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if prior authorization is required. ◆ No—if prior authorization is <u>not</u> required.

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

To add another drug list, click **Add Drug List** (Figure 2H-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 2H-2. Add Drug List Button

Drug List ID 1		Drug List ID 2	
RXCU#	Tier Level	Prior Authorization Required	Step Therapy Required
405550	3	No	No
405551	2	No	Yes
405552	1	No	No
405553	1	No	No

To remove a drug list, click **Remove Drug List** (Figure 2H-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 the data from the last created drug list and paste it into the drug list you wish to delete to overwrite the data you wish to remove, 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 2H-3. Remove Drug List Button

Drug List ID 1		Drug List ID 2	
RXCU#	Tier Level	Prior Authorization Required	Step Therapy Required
405550	3	No	No
405551	2	No	Yes
405552	1	No	No
405553	1	No	No

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	<p>Click Create Formulary IDs to create the formulary IDs.</p> <ul style="list-style-type: none"> ◆ A pop-up dialog box will appear and prompts you to enter the number of formularies.

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ 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 <i>Formulary ID</i> column.
Formulary ID	<p>Select the formulary ID from the drop-down menu.</p> <ul style="list-style-type: none"> ◆ After a formulary ID is selected, the template populates some cells and grays out others that do not apply. When a cell is grayed out, it is locked and cannot be edited. 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	<p>Select the appropriate drug list ID from the drop-down menu. The menu is auto-populated with the drug list IDs that were created on the Drug Lists worksheet. If the Drug Lists worksheet has not been completed, you must complete it before you can proceed.</p>
Number of Tiers	<p>Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary 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.</p>
Drug Tier ID	<p>Do not edit the <i>Drug Tier ID</i> 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.</p>
Drug Tier Type	<p>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.</p> <ul style="list-style-type: none"> ◆ If a tier contains both preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, 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 each tier should have unique 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. <p>Zero Cost Share Preventive Drugs:</p> <ul style="list-style-type: none"> ◆ 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 <i>Explanation</i> field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page. <p>Medical Service Drugs:</p> <ul style="list-style-type: none"> ◆ 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.

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ 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	<p>This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i>. 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:</p> <ul style="list-style-type: none"> ◆ 1 Month In Network Retail Pharmacy (Copayment & Coinsurance) ◆ 1 Month Out of Network Retail Pharmacy Benefit Offered? ◆ 1 Month Out of Network Retail Pharmacy (Copayment & Coinsurance) ◆ 3 Month In Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month In Network Mail Order² Pharmacy (Copayment & Coinsurance) ◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance).
Benefit Offered	Select Yes if the pharmacy benefit is offered for the corresponding tier. Otherwise, select No .
Copayment	<p>Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). 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	<p>Enter the coinsurance amount for the given pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). 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.

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).

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 *Benefit 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 Drugs tier should be listed first. Subsequent tiers in the formulary structure should be higher cost-sharing tiers listed in ascending order. Place the Medical Service Drugs tier as the last tier for all formulary designs.

Under the Patient Protection and Affordable Care Act (PPACA), preventive services 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 web page](#) on [HealthCare.gov](#).

We recommend you place preventive drugs in a separate Zero Cost Share Preventive Drugs 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 *Benefit 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 Drugs tier, remove the Medical Service Drugs tier and add a Zero Cost Preventive Drugs tier as the first 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 Drugs 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.

You are now required to have four drug tiers for all SPOs. Enter the cost-sharing for generic drugs for Tier 1, the cost-sharing for preferred brand drugs for Tier 2, the cost-sharing for non-preferred brand drugs for Tier 3, and the cost-sharing for specialty drugs for Tier 4. You may add the Zero Cost Share Preventive Drugs tier and the Medical Service Drugs tier in addition to the four tiers specified in this plan design, if so desired. If you choose to include the Zero Cost Share Preventive Drugs tier type, that tier type must be entered as Tier 1 for the associated formulary ID and if you include the Medical Service Drugs tier type that tier type must be entered as the highest tier for the associated formulary ID. Finally, if you choose to include both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types, then you should enter Zero Cost Preventive Drugs for Tier 1, Generic Drugs for Tier 2, Preferred Brand Drugs for Tier 3, Non-preferred Drugs for Tier 4, Specialty Drugs for Tier 5, and Medical Services Drugs for Tier 6.

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 MPMS.

Template Validation and Submission Step	Step Description
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 and Submission Step	Step Description
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 Plan Validation Workspace in MPMS.
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 and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Prescription Drug section of the QHP Application Instructions.