Qualified Health Plan
Issuer Application Instructions

2019

04/09/2018

Version 1

Section 2C: Prescription Drug

1. Introduction

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

2. Data Requirements

To complete this section, issuers will need the following:

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

3. Quick Reference

Key Changes for 2019
◆ No major changes for the 2019 QHP Application.

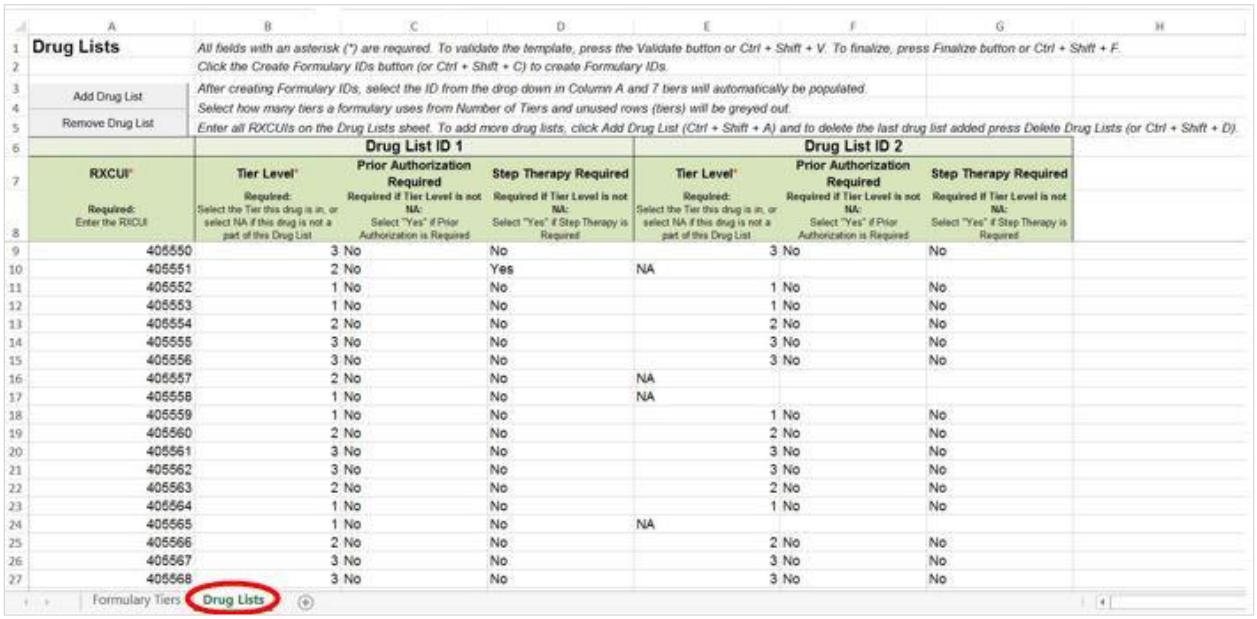
Tips for the Prescription Drug Section
◆ RxCUIs should have one of the following Term Types (TTYs): semantic branded drug (SBD), semantic clinical drug (SCD), brand name pack (BPCK), or generic pack (GPCK). ◆ Set **Tier Level** equal to "NA" (not applicable) if the drug is not part of a given drug list.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

4. Detailed Section Instructions

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

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

Figure 2C-1. Drug Lists Worksheet



Drug Lists

All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.
Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.
After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.
Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.
Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).

Add Drug List
Remove Drug List

	Drug List ID 1			Drug List ID 2		
RXCUI* Required: Enter the RXCUI	Tier Level* Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Prior Authorization Required Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Step Therapy Required Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Tier Level* Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Prior Authorization Required Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Step Therapy Required Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required
405550	3	No	No	3	No	No
405551	2	No	Yes	NA		
405552	1	No	No	1	No	No
405553	1	No	No	1	No	No
405554	2	No	No	2	No	No
405555	3	No	No	3	No	No
405556	3	No	No	3	No	No
405557	2	No	No	NA		
405558	1	No	No	NA		
405559	1	No	No	1	No	No
405560	2	No	No	2	No	No
405561	3	No	No	3	No	No
405562	3	No	No	3	No	No
405563	2	No	No	2	No	No
405564	1	No	No	1	No	No
405565	1	No	No	NA		
405566	2	No	No	2	No	No
405567	3	No	No	3	No	No
405568	3	No	No	3	No	No

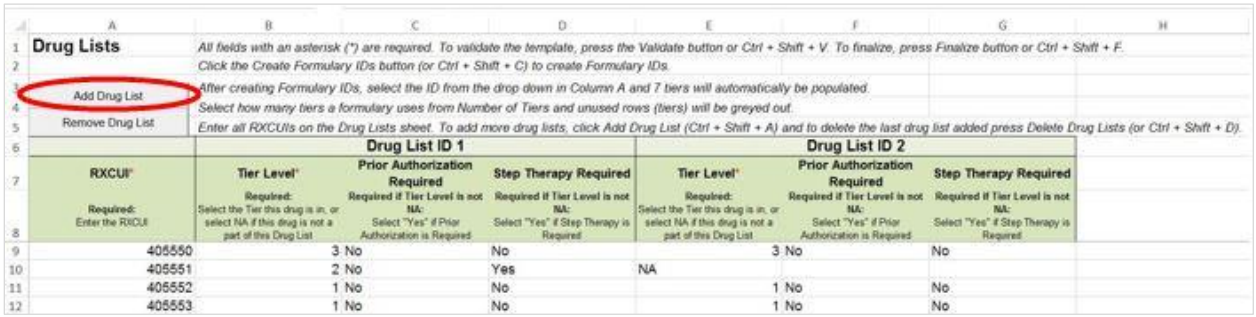
Formulary Tiers | Drug Lists

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

Drug List	Steps
RxCUI	◆ When selecting RxCUIs to include, use the October 2, 2017, full monthly release of RxNorm to find a list of valid RxCUIs. Download the RxNorm release at https://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html. To download the file, the issuer will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. The issuer can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. ◆ CMS posts the EHB Rx Crosswalk and a reformatted RxNorm database along with the state review tools at https://www.qhpcertification.cms.gov/s/Review%20Tools. ◆ RxCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK. ◆ The drug list should include all drugs on the issuer's formulary, even if they do not fall in one of the categories and classes identified in the summary of EHB benchmark information, available at https://www.qhpcertification.cms.gov/s/Prescription%20Drugs. This includes all drugs deemed by the user as "medical service drugs."
Tier Level	For each drug, select the RxCUI's cost-sharing tier level from the drop-down menu, or select "NA" if this drug is not part of the given drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following options: ◆ **Yes**—if prior authorization is required. ◆ **No**—if prior authorization is *not* 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 options: ◆ **Yes**—if step therapy is required. ◆ **No**—if step therapy is *not* required. If Tier Level is "NA," leave this column blank.

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

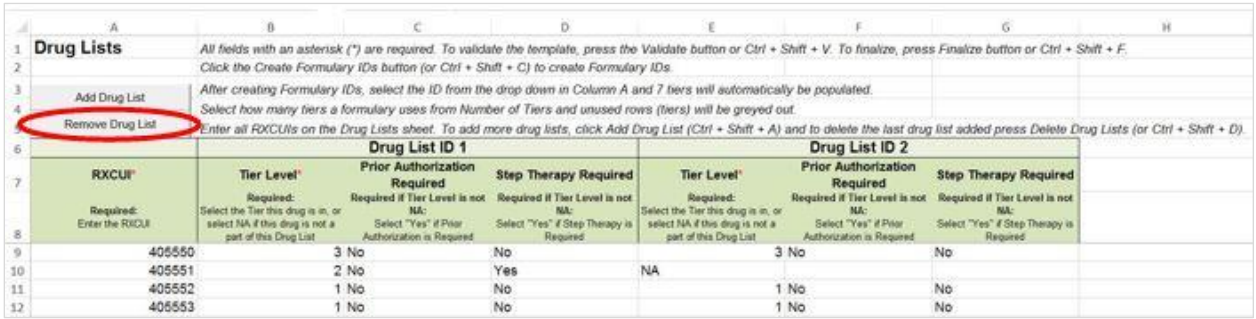
Figure 2C-2. Add Drug List Button



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

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

Figure 2C-3. Remove Drug List Button



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

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Select the state for which the template applies from the drop-down menu.
Generate Formulary IDs	Click the **Create Formulary IDs** button 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 plus an "F," and then a sequenced number (such as ALF001 and ALF002). ◆ Once completed, the formulary IDs appear in a drop-down menu in the Formulary ID column.

Formulary Tiers	
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.
Formulary URL	Enter the URL (web address) for the formulary document or website. CMS expects the URL link to direct consumers to an up-to-date formulary where they can view the covered drugs, including tiering, specific to a given QHP. The URL provided to the Exchange as part of the QHP Application should link directly to the formulary, such that consumers do not have to log on, enter a policy number, or otherwise navigate the issuer's website before locating it. If an issuer has multiple formularies, it should be clear to consumers which formulary applies to which QHPs. CMS makes issuer-provided formulary links available to consumers on HealthCare.gov.
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, do so now.
Number of Tiers	Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary should correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created within a tier. All drugs within the same tier should have the same cost sharing.
Drug Tier ID	The template populates this column according to the selection in Number of Tiers. The other cells are grayed out, indicating they do not apply. The Drug Tier ID column is controlled by the template; do not edit it.
Drug Tier Type	Click the drop-down menu, and select the **Click here to select** option to open a pop-up dialog box. Choose from the following options, and select a maximum of two drug types, one generic type, and one brand type for each tier. No additional tier type can be selected for Zero Cost Share Preventive Drugs. No additional tier type can be selected for Medical Service Drugs. ◆ If a tier contains both preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, then choose the tier type of preferred generic. The same applies for a tier with preferred and non-preferred brand drugs. ◆ Multiple tiers may have the same drug tier types, but tiers should have different cost sharing. ◆ 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, it is the only tier type that can be selected for the tier. It is preferred that the issuer place the Zero Cost Share Preventive Drug tier as Tier 1 if applicable, to represent the lowest-cost tier to the consumer. ◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance information will automatically be set to **$0** and **0 percent**, respectively, when this tier type is chosen. The remaining pharmacy benefit types can still be edited. If the remaining pharmacy benefits are offered, then the subsequent cost-sharing fields should be entered as **$0** and **0 percent**. ◆ If the issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Explanation field of the Plans & Benefits Template and in a plan brochure and formulary URL.

Formulary Tiers	Steps
	Medical Service Drugs: ◆ Use this tier type to indicate if a formulary contains medical service drugs. CMS recognizes that there are some state benchmarks that contain medical service drugs in various categories and classes; therefore, a Medical Service Drugs tier can assist in identifying these drugs in the formulary. ◆ When Medical Service Drugs is selected, it is the only tier type that can be selected for the tier. ◆ The 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. Complete the information for the other three pharmacy types only if they apply to the given drug tier, but the issuer must indicate whether each tier offers these types of pharmacy benefits. The pharmacy benefits are as follows: ◆ 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[3] 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	Enter the copayment amount for the given pharmacy type. The copayment field allows values to the hundredths decimal. Round any copayments to the hundredths decimal. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). Note that **Not Applicable**, *not* **No Charge**, should be used if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. Note that when using **Not Applicable** for copay, **Not Applicable** cannot be used for coinsurance (unless the drug tier type is **Medical Service Drugs**).

[3] Pursuant to 45 CFR 156.122, for plan years beginning on or after January 1, 2018, a health plan providing EHBs at in-network retail pharmacies, unless the drug meets an exception under 45 CFR 156.122(1)(i) and (ii).

Formulary Tiers	Steps
Coinsurance	Enter the coinsurance amount for the given pharmacy type. The coinsurance field allows values to the hundredths decimal. Round any coinsurance to the hundredths decimal. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). Note that **Not Applicable**, *not* **No Charge**, should be used if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay. Note that when using **Not Applicable** for coinsurance, **Not Applicable** cannot be used for copay (unless the drug tier type is **Medical Service Drugs**).

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

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

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

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

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

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

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

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

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

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