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John R. Kasich, Governor

Mary Taylor, Lt. Governor/Director

Industry Training Webinar
April 14, 2016

2017 Plan Year Binders

Presenters

- Laura Miller – Assistant Director, Product Regulation & Actuarial Services
- Chris Wright – Life & Health Regulatory Process Mgr., Product Regulation & Actuarial Services
- Laura Schimpf – Contract Analyst, Product Regulation & Actuarial Services

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2017 Plan Year Binders

Agenda for Today's Webinar

- Overview
- 2017 Binder Components
- Stand-Alone Dental Plans (SADPs)
- CMS Data Review Tools
- Issuer Resources
- Q&A
- Closing Remarks

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Overview of 2017 Binder Process

- Review of General Requirements
- Plan Management Review Standards
- Timelines

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Review of General Requirements

- Who must submit Binders?
  - All Issuers planning to offer major medical and stand-alone Dental plans on the Health Insurance Exchange ("Exchange") in 2017

    and
  - All Issuers planning to offer Off-Exchange Certified SADPs in 2017

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Review of General Requirements (cont'd)

- Only one Binder submission
  - Per Market for medical and/or for stand-alone dental
    - Market
      - Individual
      - Small Group
  - Per Issuer
    - Identified by a unique NAIC and a corresponding HIOS Issuer ID number
    - Combine indemnity and HMO plans in same Binder

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Review of General Requirements (cont'd)

- All Ohio Binders must be filed in SERFF *(State Electronic Rate and Form Filing System)* under the Plan Management tab
  - Do not submit a QHP application in HIOS
  - Access to Plan Management features in SERFF is governed by specific User Roles

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Review of General Requirements (cont'd)

- Critical steps for the initial Binder submission in SERFF
  - Include all plans in the Binder intended to be offered in that market (*plans can't be added after Binder is submitted in SERFF*)
  - Run the Data Integrity Tool and correct any valid data errors to avoid validation errors during data transfer to HIOS
  - Ensure that templates are in Cross-Validation Complete status (allows the template to be submitted to the state in SERFF)

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Review of General Requirements (cont'd)

- Form vs. Rate vs. Binder Synchronization

Filing contacts should communicate throughout review process so all documents and templates are current

- Form filing – verify consistency against Plans & Benefits Template for:
  - Essential Health Benefits (EHBs)
  - Cost Sharing Structures (e.g., integrated cost-sharing, HSA eligible plans)
- Rate filing – verify consistency against Plans & Benefits Template for:
  - EHB Apportionments
  - AV Calculator values

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Plan Management Review Standards

- ODI will review Binder filing components that are required by CMS for State Plan Management ("SPM") in accordance with applicable standards and instructions published by CMS, including, but not limited to 2017 Plan Year:
  - Final Letter to Issuers
  - Final Payment Notice
  - CMS QHP Application Instructions
  - CMS QHP Review Tools

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Timelines

State Plan Management

Ohio Binder Process Timeline

2017 Plan Year Activity	Due Date
Form Filings Due (Major Medical and Stand-Alone Dental)	4/15/2016
Rate Filings Due - Stand-Alone Dental - Individual and Small Group Major Medical	 4/27/2016 5/13/2016
Binder Submissions Due	**4/27/2016**
Deadline for 1st SERFF Data Transfer	5/11/2016
CMS 1st Correction Notices	6/16/2016
Deadline for 2nd SERFF Data Transfer	6/30/2016
CMS 2nd Correction Notices	8/09/2016
Deadline for Final SERFF Data Transfer (Data Lockdown)	**8/23/2016**
CMS On/Off Track Notices	9/13/2016
Certification Notices and QHP Agreements sent to Issuers	9/16/2016
Deadline for Issuer return to CMS of signed QHP Agreements and Final Plan List	9/23/2016
Validation Final List of Certified QHPs and countersigned QHP Agreements	10/4/2016
Open Enrollment Begins	11/01/2016

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Timelines (cont'd)

- Plan Management Binder functionality for Ohio is currently available in SERFF for issuers to draft and submit 2017 Binders
  - Watch for SERFF communications and check CMS QHP Certification website regularly for updates

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2017 Binder Components

- 2017 Binder Component Overview
- Issuer Components
- Benefit and Service Area Components
- Plan ID Crosswalk
- Rating and Rate Review Components

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2017 Binder Component Overview

- Components no longer required for 2017 Ohio Binder submissions:
  - Administrative Template
  - SHOP Tying Form
  - URRT and Part III Actuarial Memo
- New CMS required Binder component for 2017
  - Quality Improvement Strategy Certification Requirement
    - QIS Implementation Plan and Progress Report Form

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2017 Binder Component Overview (cont'd)

- Significant Changes to Previous Components
  - Network Adequacy/Essential Community Provider data templates
    - ECP Write-in Worksheet
  - Plans & Benefits template Add-in files
    - Standard Plan Add-in file updated for 2017 Essential Health Benefits
    - New Standardized Options Plan Design Add-in file (optional)

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Issuer Components

- Business Rules Template
- Accreditation
- State Plan Management (SPM) Attestations Document
- Compliance Plan & Organizational Chart
- Justifications and Supporting Documentation

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Issuer Components (cont'd)

- Correct Issuer name, NAIC Code and HIOS ID's
  - Should be consistent with the applicable values registered in HIOS
- New for 2017 – No Administrative Template required for Binders
  - Administrative information will be pulled from the "Issuer General Information Fields" and the Marketplace General Information Fields" in HIOS for all QHP and SADP issuers
- No Licensure or Good Standing documentation required

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Issuer Components (cont'd)

Business Rules Template

- Only one each per issuer/HIOS Issuer ID
- Exact copy of same template must be used for each Binder submission (QHPs/SADPs for both Individual and Small Group markets)
- Important Business Rules tips
  - Reminder: Use most common (Issuer ID level) Business Rules for Row 10 and enter additional Product ID and/or Standard Component Plan ID level rows to customize as needed
  - Maximum dependent age (column F) is the "thru" age (i.e., if eligibility stops at attainment of age 27, enter 26 in the template, not 27)
  - Review special instructions applicable specifically to SHOP plans and SADPs, for example:
    - SHOP Dependent relationships (Column L)
    - SADP Calculation of Rates for 2+ Enrollees (Column D)

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Issuer Components (cont'd)

Accreditation

- Accreditation data pulled from accrediting entities and submitted to HIOS by SERFF – No template required
- New "Marketplace" accreditation required for 4th year QHP issuers

2017 Plan Year QHP Issuer Accreditation Requirements Note: Issuers must meet Accreditation status requirements 90 days prior to open enrollment.	
Initial Year of Exchange QHP Participation	**2017 Plan Year Accreditation Requirements**
2014	Issuers entering their fourth year of Exchange QHP participation must be accredited in the Marketplace market with the following status: Accreditation Association for Ambulatory Health Care (AAAHC)—Accredited National Committee for Quality Assurance (NCQA)—Excellent, Commendable, Accredited, or Provisional; or URAC—Full or Conditional
2015 or 2016	Issuers entering their second or third year of Exchange participation must be accredited by a recognized accrediting entity (AAAHC, NCQA, or URAC) in at least one of the Commercial, Medicaid, or Marketplace markets.
2017	Issuers participating in the Exchange for the first time in 2017, if not already accredited, must schedule (or plan to schedule) a review with a recognized accrediting entity (AAAHC, NCQA, or URAC).

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Issuer Components (cont'd)

State Plan Management (SPM) Attestations Document

- CMS has incorporated all required Attestations in the 2017 SPM document
  - Use only the SPM version of the Attestation document
  - Document header – 'State Partnership Marketplace Issuer Attestations: Statement of Detailed Attestation Responses'
- All issuers must complete the entire SPM version of the Issuer Attestation Document
- For 2017 PY, issuers must answer "Yes," on all but compliance plan attestation (justification required).
  - Review CMS instructions
- Updated attestation requirements for 2017 PY:
  - Essential Community Providers (ECPs)
  - Network Adequacy

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Issuer Components (cont'd)

Compliance Plan & Organizational Chart

- Each of the 3 components should be attached as a separate document for this Requirement in SERFF
  - Cover Sheet Template
  - Compliance Plan
  - Organizational Chart
- Issuer should be indicated as included in scope of the Compliance Plan
- Issuer name should be shown on the Organizational Chart

Benefit and Service Area Components

- Service Area Template
- Network ID Template
- New ECP/Network Adequacy Template
- Prescription Drug Template
- Plan/Benefit Template
  - Ohio Benchmark EHB Add-In file
  - New Standard Plan Options Add-In file
- Justifications and Supporting Documentation
  - Several updates for 2017
  - Review specific CMS instructions for requirements

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Benefit and Service Area Components (cont'd)

- Network ID, Service Area, and Rx Formulary/Drug Templates
  - No substantive changes for PY 2017
  - Complete these templates before completing the Plans & Benefits Template

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Benefit and Service Area Components (cont'd)

Service Area Template

- One template per issuer
  - Multiple tabs to define multiple service areas
- Not product specific
- Used with Medical and Dental plans
- Zip code entry - only for partial county Service Area (justification required demonstrating non-discriminatory)
- Any changes to Service Area Template after initial transfer deadline of May 11th, require submission of a Data Change Request and approval from CMS

Network ID Template

- One template per issuer (including dual medical and dental product issuers)
- Use the word “dental” in the Network ID Name for dental networks
- Same Network (Network ID) can be associated to multiple plans

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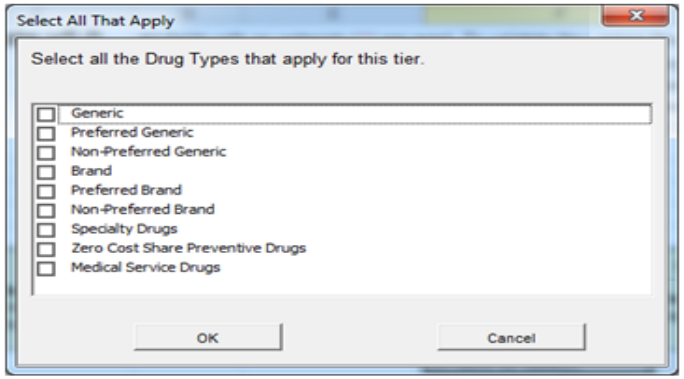
Benefit and Service Area Components (cont'd)

Prescription Drug (Rx) Template

- No substantive changes, but certain completion requirements important to support new review tool
- All covered drugs should be included on Drug List to work properly with the new review tool
  - Medical Service Drugs and Preventive Drugs
    - Additional tier can be assigned for drugs that are not part of the standard prescription drug benefit
  - Select all Drug Types that apply to a tier (multi-selection not available for Zero Cost Share Preventive or Medical Service Drugs)



  - If drug included in at least one, but not all of multiple drug lists, select “N/A” for tier level and “No” for prior authorization and step therapy columns

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Benefit and Service Area Components (cont'd)

Prescription Drug (Rx) Template (cont'd)

- One Formulary ID per unique Drug List
  - A unique Drug List must have same number of drug tiers and drug tier types
  - "Remove Drug List" button should be used to remove any drug lists not used for plans on Plans & Benefits Template
- Check Copay and Coinsurance field automatic default values
  - Review template instructions
  - Copayment and Coinsurance can't both be "Not Applicable," except for Medical Service Drugs
- Justification document
  - Select from pre-defined reason or provide other detailed explanation
  - Include specific drug name(s) in justification
- Rx formulary URLs
  - Must link directly to specific drug listing for plan

Benefit and Service Area Components (cont'd)

Plans and Benefits Template

- Carefully read CMS Instructions
- Updated Add-In File Includes all 2017 PY Ohio Benchmark Essential Health Benefits (EHBs)
  - All Ohio EHBs are included in one of the "standardized" 67 benefit/service line Items
  - Do not manually add additional EHB benefit line items
  - Do not enter an EHB Variance Reason if only the Explanation field is changed
  - Correction may be needed to "Covered/Not Covered" field for "Infertility Treatment" line item

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- Updated 2017 PY Plans & Benefits Template Add-In File – v6.4
  - Corrections needed to the Benefit Package line item for "Infertility Treatment" are indicated below in **Red Text**

Type of Plan	EHB	Is This Benefit Covered?	EHB Variance Reason
Title 1751 Health Insuring Corporation (HMO) Benefit Package that includes state-mandated coverage for Infertility Treatment	YES	Covered	**Additional EHB Benefit**
Title 39 Indemnity (non-HMO) Benefit Package that does not cover Infertility Treatment	YES	**Not Covered**	**Not EHB**
Title 39 Indemnity (non-HMO) Benefit Package that does cover Infertility Treatment (above EHB benefit) – *must also complete the applicable EHB Apportionment value.*	YES	Covered	**Not EHB**

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- Updated 2017 PY Plans & Benefits Template Add-In File – v6.4 (cont'd)
  - If a Cost Share Variances worksheet has already been created that does not include cost sharing for the "Infertility Treatment" benefit the Cost Share Variances worksheet must be deleted and re-created using the "Create Cost Share Variances" macro in the updated Add-In file
  - CMS Guide to Copying and Pasting in Templates
    - Use the updated instructions for 2017 Templates

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- EHB Variance values updated
  - "Above EHB" eliminated
  - Use "Substantially Equal" for benefits more generous than EHB and provide applicable EHB Apportionment value
  - Use new value of "Not EHB" only for a benefit/service that is not covered and not an EHB
- Exclusions and Explanation Field Text
  - Complete for all applicable benefit/service line items
  - Should closely match information listed on the "Ohio Essential Benefit Resource Document for 2017 Plan Year"
  - Should agree with form language and correspond to information in the SBC and plan brochure documents

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- Other updates include:
  - "Minimum Stay" and "State Required Benefit" fields removed
    - All Ohio state required benefits already included in standard EHB line items
  - Actuarial Value (AV) Calculator Additional Benefits fields moved to Cost Share Variances at a plan variation level
  - New "Design Type" field indicator for optional standardized plan designs – also included for standard plans, but should default to "Not Applicable"
  - "Subject to Deductible" field removed from the Benefits Package sheet. Deductible is now mapped based on "Copay" and "Coinsurance" values entered

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- Changes to the Cost Share worksheet
  - SBC (Summary of Benefits and Coverage) data scenarios - medical QHPs only
    - Completion of SBC Scenarios required
    - SBC Scenarios must correspond with applicable plan brochure
    - Use the current SBC calculator
    - New (3rd) SBC Scenario for "Treatment of a Simple Fracture"
      - See CMS "final" guidance released 4/6/2016
  - *"EHB Apportionment for Pediatric Dental"* field should be completed as a percentage, not a dollar amount
  - Copay and coinsurance values now accommodate up to 2 decimal places
  - *"Plan Marketing Name"* field renamed to *"Plan Variant Marketing Name,"* - can be edited at plan variation level

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Benefit and Service Area Components (cont'd)

Plans and Benefits Template (cont'd)

- Important Checks and Reminders…

✓ Cost Sharing amounts ("Copay" and "Coinsurance") must reflect what the consumer pays

✓ Ensure correct values are entered into "pop-up box" fields for individual and family maximum out of pocket amounts

✓ Plans that have the same benefits should be entered on the same Benefit Package Tab regardless of cost sharing variances

✓ HSA Eligible Plans

- Verify cost-sharing data is correct, especially for MOOP and deductible
- For SHOP, the HSA/HRA Employer Contribution and Contribution Amounts must be completed if plan is indicated as HSA Eligible

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Benefit and Service Area Components (cont'd)

Justifications and Supporting Documentation

- Provide additional explanatory justifications and/or documents on the Supporting Documents tab, as required
  - Most justification forms should be included in the SERFF requirements on the Supporting Documents tab
  - Several updates to documentation requirements and forms
  - Use 2017 versions and review CMS instructions for changes in requirements

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Benefit and Service Area Components (cont'd)

Justifications and Supporting Documentation (cont'd)

- Quality Improvement Strategy - QIS Implementation Plan and Progress Report Form
  - Issuers required to participate for 2017 must submit completed QIS form in Binder under the Supporting Documentation tab
  - Issuers required to participate must implement at least one QIS per On-Exchange Marketplace and each eligible QHP must be included in a QIS plan
  - QIS requirements not applicable to Off-Exchange plans, child-only plans, SADPs, or QHPs that are compatible with HSAs

Benefit and Service Area Components (cont'd)

Justifications and Supporting Documentation (cont'd)

- Quality Improvement Strategy - QIS Implementation Plan and Progress Report Form (cont'd)
  - CMS 2017 QIS Issuer Participation List
  - Issuer Participation Criteria
    - Issuers that offered QHPs on the Exchange in 2014 and 2015 (2 consecutive years)
    - Issuers that provide family and/or adult-only QHP medical coverage
    - Issuers that offered a QHP with more than 500 enrollees as of July 1, 2015, when Individual and SHOP enrollees are added together for the same product type (e.g., HMO, PPO, POS)

Benefit and Service Area Components (cont'd)

Justifications and Supporting Documentation (cont'd)

- Quality Improvement Strategy - QIS Implementation Plan and Progress Report Form (cont'd)
  - 2017 QIS Form Completion Requirements
    - QIS Submission Type should indicate the issuer is submitting a "New" QIS
    - Issuers must complete Parts B – E per instructions provided in the QIS Technical Guidance and User Guide
      - Response required to all criteria in each element
    - Part F is prospective and should not be completed for the 2017 submission

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Benefit and Service Area Components (cont'd)

New combined ECP/Network Adequacy Template and ECP Write-In Worksheet for the 2017 PY

- Dual issuers must submit separate ECP/Network Adequacy Template for medical and dental Binder submissions
- Only ECPs and locations available on drop-down can be entered on the ECP portion of the template – template will not allow manual data entry of corrections or "write-ins"
- New separate "ECP Write-In Worksheet" for "conditional" write-ins of ECPs that have not yet submitted petitions to CMS
- CMS will periodically post updates to the "Available ECP Write-In List for PY 2017," indicating ECPs that have submitted petitions during the review period (last update to be posted 8/23/2016)

Benefit and Service Area Components (cont'd)

New combined ECP/Network Adequacy Template and ECP Write-In Worksheet (cont'd)

- Only ECP write-ins that actually submit a petition on or before 8/22/2016, will be counted toward meeting ECP 30% standard
- For 2017, 30% standard will be calculated on a "Facility" rather than on a "Full-Time Employee (FTE)" basis - *FTE basis will take effect for 2018*
- Supplementary Response for issuers not meeting ECP requirements
- Demonstration:

  Step-by-Step Completion of the 2017 PY ECP/Network Adequacy Template

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Plan ID Crosswalk Template

- Main purpose:
  - To facilitate auto re-enrollment 834 transactions in support of guaranteed renewability standard for Individual On-Exchange market
- Required for all issuers that offered Individual market QHPs through the Exchange in 2016 including SADPs
- No guaranteed renewability standard for SADPs
- CMS deferred SHOP auto renewability for PY 2017
  - No Crosswalk template submission for 2016 SHOP plans

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Plan ID Crosswalk Template (cont'd)

- Required as part of QHP Application process and must be submitted by email directly to CMS by May 11, 2016
  - CMS E-mail address for Plan ID Crosswalk Template submission: QHP_Applications@cms.hhs.gov
  - Email the generated XML file to CMS
- Identical template must also be included in the initial QHP Binder submission to Ohio
- Submit in Excel (.xls) format on Supporting Documentation tab
- Any subsequent updates to CMS must also be updated in QHP Binder

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Plan ID Crosswalk Template (cont'd)

- State authorization is not required for the initial May 11, 2016, Binder submission
  - Authorizations will be provided prior to the 6/30/2016 and/or 8/23/2016 update submission deadlines (as applicable)
    - State reauthorization required to be submitted to CMS for updated crosswalk template submissions
- Crosswalk of plans must meet Uniform Modification Requirements
  - Same Plan ID standards

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Plan ID Crosswalk Template (cont'd)

- 2017 Updates
  - Updates made to improve Plans & Benefits template and Service Area data import functionality
    - Must use the Plans & Benefits and Service Area templates finalized for plan year 2016
      - Template will not allow import of templates from any other plan year
    - Only select one of each template
  - New "*Reason for Crosswalk*" entry for scenarios where a silver plan is cross-walked to another silver plan in a different product
  - Updated review tool available

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Plan ID Crosswalk Template (cont'd)

- *"Associated Policy Form Number(s)"* and *"NAIC SERFF Tracking Number(s) for Form Filing(s)"* fields are optional at State request and are not required for Ohio Binders

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Rating and Rate Review Components

- No substantive Rate Data Template changes for PY 2017
  - Use “best estimate” rates to complete initial template submission and update with “final” rates as needed
  - Include rates for all plans and service areas
  - Synchronize any updates/changes in rate filing components with Binder template and HIOS rate submissions
- No URRT or Part III Actuarial memo needed in Binder
  - Associate Rate Filing in Binder

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Rating and Rate Review Components (cont'd)

- Successive Cost Sharing Rule
  - Applies to cost-sharing elements for all Essential Health Benefits
  - Check to ensure cost-sharing for higher level AV is an equal or better benefit to the consumer
- Use Rate Template level validation
  - Separate from the Cross-Validation Complete process that enables SERFF submission
- The actuary must print his/her credentials (ASA, FSA, ACAS, etc.) within all required actuarial certifications

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Stand-Alone Dental Plans

Stand-alone Dental Plans (SADP)

- Includes On-Exchange and Off-Exchange Certified plans
- Binder timeline will follow the same timeline as that of medical plans
- Not reviewed for accreditation status
- Must answer "Yes" to all non-optional attestations
- Plan Crosswalk Template is required for issuers that offered Individual market SADPs in 2016
- Plans & Benefits template includes customization for SADPs
  - Review details in CMS instructions

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Stand-Alone Dental Plans (cont'd)

- 2017 Update for Stand-alone Dental Plans (SADP)
  - EHB Apportionment for Pediatric Dental
    - Enter the percentage (instead of the dollar amount) of monthly premium allocated for the pediatric dental EHB
    - For age banded rates, use the EHB percent of the 0- to 20-year-old rate
    - For family rates, use the EHB percent of the individual rate assuming a child enrollment
  - SADPs must also submit as Supporting Documentation:
    - "Stand-Alone Dental Plans—Description of EHB Allocation" and
    - "Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification"

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CMS Data Review Tools

- CMS has updated template data review tools and expects issuers to use them to avoid portal display errors that could result in plan suppression
- ODI will also use the updated CMS review tools to review Binder template data
- Use updated 2017 versions found on the CMS QHP website:

  http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
- For documentation purposes and review efficiency, issuers should document results of review tools they have used and include an explanation of errors the issuer believes are invalid. This documentation should be attached to one or more Notes To Reviewer in the Binder filing

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CMS Data Review Tools (cont'd)

- Data Integrity Tool (DIT) – most important tool
  - It is important for all issuers to run the DIT on their Binder template data before their initial submission in SERFF and to document/explain any "invalid" DIT errors not corrected prior to Binder submission
  - The DIT conducts checks designed to prevent critical system validation and/or portal display errors
  - Improved, more specific error and warning messages
    - Alerts users to irregularities in template submissions along with the location of these irregularities
  - Reference List included with DIT download provides a key to assist users in understanding errors and necessary corrections

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CMS Data Review Tools (cont'd)

- Significant updates to other 2017 review tools:
  - Plan ID Crosswalk tool
    - Added check to ensure 2016 silver plans are always cross-walked to a 2017 silver plan when available
  - Master Review Tool
    - Added Silver/Gold check to ensure offering of at least one silver and one gold plan in every covered medical market
    - Imports Rx data
    - Imports ECP data from new ECP/NA template
  - Meaningful Difference Tool
    - Only reviews benefits displayed to consumers on Healthcare.gov
    - Uses drug list ID instead of formulary ID for comparison
    - Increased difference requirements for MOOP and deductible

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CMS Data Review Tools (cont'd)

- Significant updates to other 2017 review tools (cont'd)
  - Essential Community Providers (ECP) Tools (updates to for both QHP and SADP reviews)
    - Evaluates additional ECP categories
  - Non-Discrimination Tool
    - No longer reviews SBC Scenarios
    - Not really helpful unless run with data for all plans within a state market
  - Cost Sharing Tool
    - Includes new review for plans that follow a Standardized Plan

CMS Data Review Tools (cont'd)

- Significant updates to other 2017 review tools (cont'd)
  - Formulary Review Suite
    - Incorporates Category Class Drug Count Review, Non-Discrimination Formulary Outlier Review, and Non-Discrimination Clinical Appropriateness Review into one tool "suite"
    - Category Class Drug Count uses USPv6 categories and classes
    - Individual drug list results no longer exported into separate files -- located on 2 output tabs within the review suite
    - All RxCUIs Submitted Report is now a stand-alone export that provides a list of every RxCUI submitted on a drug list
      - Indicates retired and reassigned RxCUIs and identifies the chemically distinct drug impacted by a particular RxCUI

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CMS Data Review Tools (cont'd)

- Significant updates to other 2017 review tools (cont'd)
  - Formulary Review Suite (cont'd)
    - Non-Discrimination Clinical Appropriateness Review includes checks for 9 health conditions (5 more conditions than for the 2016 PY)
      - Bipolar disorder, breast cancer, diabetes, Hepatitis C, HIV, multiple sclerosis, prostate cancer, rheumatoid arthritis, and schizophrenia
    - The EHB Rx Crosswalk and a reformatted RxNorm database are posted with the tool suite on the CMS QHP website

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Issuer Resources

- ODI Website Plan Management Toolkit: (http://insurance.ohio.gov/Company/Pages/ACA-Plan-Management-and-Filing-Guidance.aspx)
  - Separate tab for "Binder Filing Guidance"
    - Will be updated with additional information during the Binder review process
  - Resource Documents tab
    - 2017 ECP and Prescription Drug EHB listings will be posted very soon
  - Important Announcements
  - FAQs
    - Organized by year and category

****Register to receive email notification of significant announcements and updates****

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Issuer Resources (cont'd)

- NAIC/SERFF:
  - Health Insurance Exchange Plan Management (HIX) Webpage http://www.serff.org/hix.htm
    - New On-Demand Tutorials
    - Direct links to CMS QHP website
      - Most current versions of data templates and review tools
  - SERFF Application Online Help - Plan Management section
    - Information about SERFF functionality supporting Plan Management Binders
  - Plan Management General Instructions
    - Under "Plan Management" tab in SERFF
    - State specific instructions for Binder filings

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Issuer Resources (cont'd)

- CMS/CCIIO QHP website: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
  - Detailed Instructions by QHP Application Area
    - Includes Revision History documentation
  - Most current versions of 2017 PY:
    - QHP Data Templates
    - QHP Review Tools
    - AV Calculator
  - 2017 Supporting Documentation Forms: Attestations, Justification, etc

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Issuer Resources (cont'd)

- CMS/CCIIO QHP website: (cont'd)
  - CMS QHP Application Toolkit for Issuers

    https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/QHP-Certification-Toolkit_03-28-2016.pdf

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Q & A

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Closing Remarks

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