Qualified Health Plan Issuer Application Instructions

2022

Extracted section:
Section 2C: Prescription Drug

[02/2021]

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.

---

[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, <u>full monthly release of RxNorm data</u> 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 <u>National Library of Medicine</u>. ◆ Find the EHB RX Crosswalk, a reformatted RxNorm database, and state review tools on the Center for Consumer Information and Insurance Oversight (CCIIO) <u>Review Tools page</u>. ◆ 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 <u>summary of EHB benchmark information</u>. 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.

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)

---

[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 not subject to the deductible). Use **Not Applicable**, not **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).
	◆ **$X**—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).
	◆ **$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 not subject to the deductible). 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%**—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is not 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.