Chapter 13: Instructions for the Business Rules Application Section

Contents

Chapter 13: Instructions for the Business Rules Application Section 13-1
1. Overview 13-1
2. Purpose 13-1
3. Business Rules Template Data Requirements 13-1
4. Application Instructions 13-1
4.1 HIOS User Interface Instructions 13-2
4.2 Template Instructions 13-2
4.2.1 Entering Data 13-4
4.2.2 Finalizing Template 13-13
4.3 Supporting Documentation Instructions 13-14

1. Overview

The Business Rules Template is a series of questions and answers submitted by issuers that defines the Business Rules used to calculate rates and determine if an enrollment group is eligible for coverage under a plan. This template, in conjunction with the Rates Table Template, is used to calculate the premium for each enrollment group.

2. Purpose

This chapter will guide you through completing the Business Rules Template including data requirements to complete the template, how to download the template, and instructions for each data field.

3. Business Rules Template Data Requirements

To complete this section you will need your:

1. Health Insurance Oversight System (HIOS) generated Issuer ID
2. Federal Taxpayer Identification Number (TIN)
3. HIOS generated Plan IDs

4. Application Instructions

The Business Rules Template section of the Qualified Health Plan (QHP) Application uses an Excel template to collect important rating and business rule information. Figure 13-1 contains key items to note when completing the Business Rules section.

Figure 13-1. Key Business Rules Template Section Highlights

- Download the latest version of the Business Rules Template from http://cciio.cms.gov/programs/exchanges/qhp.html.The template should be completed using Microsoft Excel 2007 or 2010. Complete template functionality may not be fully supported by Microsoft Excel 2013.
- The elements described in these instructions are in the same order as they will be found in the Business Rules Template.
- Dual product issuers should use the same template for both their QHPs and SADPs.
- Rules associated with both Individual and SHOP plans should be entered into one Business Rules Template.
- The first row of rules (row 10) is the base set of issuer business rules, which must have blank values for the *Product ID* and *Plan ID*, and data entered for all subsequent columns. This row applies to all products and plans associated with the Issuer ID, including individual, SHOP, QHP and SADP products and plans. Products or plans with rules that differ from the base set of issuer business rules are defined at the product or plan level on the subsequent rows (see 3.a and 3.b of Section 4.2.1 below).
- Market rules allow SADPs the flexibility to adjust for rating factors not present in this template, including the ability to either raise the number of child rates used to calculate premium on a single contract, or to remove this maximum altogether. In the *Plan Attributes* section of the Plans & Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments, by indicating that rates are either “Guaranteed” or “Estimated.” Plan Compare will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that on-exchange FF SHOP (Federally-facilitated SHOP) and SP SHOP (State Partnership SHOP) SADPs may not use estimated rates, and must have guaranteed rates in order to be offered on-exchange.
- In this document, data fields are in italics, and data entry options, buttons, and ribbons are bold.

4.1 HIOS User Interface Instructions

The Business Rules section of the QHP Application has no user interface questions.

4.2 Template Instructions

Issuers should complete the Business Rules Template using the instructions that follow to provide information for each health plan they wish to submit.

The Business Rules Template contains macros to finalize and validate the template. The user needs to enable macros in order for the template to function properly. See the Rating Module User Guide for instructions on enabling macros in Microsoft Excel 2007-2010. The template should be completed using Microsoft Excel 2007 or 2010. Complete template functionality may not be fully supported by Microsoft Excel 2013.

Figure 13-2 shows an example of a completed Business Rules Template.

Figure 13-2. Business Rules Template

2017 Business Rules Template v6.0

All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.

Validate

Finalize

Enter the Issuer Rule on the first row (no Product ID or Plan ID).
For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.
For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule

HIOS Issuer ID* 12345
TIN* 123456789

Product ID	Plan ID (Standard Component)	How are rates for contracts covering two or more enrollees calculated?	What are the maximum number of under age (under 21) dependents used to quote a two parent family?	What are the maximum number of under age (under 21) dependents used to quote a single parent	Is there a maximum age for a dependent?	What are the maximum number of children used to quote a children-only contract?	Are domestic partners treated the same as secondary subscribers?	Are same-sex partners treated the same as secondary subscribers?	How is age determined for rating and eligibility purposes?	How is tobacco status determined for subscribers and dependents?	What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
		There are rates specifically for couples and for families (not just addition of individual rates)	3 or more	3 or more	25	3 or more	Yes	Yes	Age on effective date	6	Spouse, Yes; Adopted Child, No; Foster Child, No; Stepson or Stepdaughter, No; Self, Yes; Child, No

<u>Note for SERFF Submitters</u>. The HIOS system only allows one set of issuer-level business rules (row 10). If an issuer submits two templates (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different issuer-level business rules (row 10), the last template uploaded by the state from SERFF into HIOS will apply to all plans, both Individual Market and SHOP, unless the product or plan is listed separately. The issuer-level rules (row 10) submitted on the first template uploaded will be overwritten by the issuer-level rules (row 10) submitted on the second template uploaded.

In order to avoid problems connected with issuer-level rule over-writes, all Business Rules Template issuer-level business rules (row 10) should be the same. Products and plans which do not adhere to the business rules described at the issuer level (row 10) should be further described in the rows below row 10, as described in item 3 in the instructions below.

4.2.1 Entering Data

Complete the following general information in the Business Rules Template:

1. *HIOS Issuer ID* (required). Enter the 5-digit numeric issuer identification number.

2. *Federal TIN* (required). Enter the 9-digit (xx-xxxxxxx) TIN.

3. The first row of rules (row 10) is the base set of issuer business rules, which must have blank values for the *Product ID* and *Plan ID (Standard Component)*, and data entered for all subsequent columns. This row applies to all products and plans associated with the Issuer ID, including individual, SHOP, QHP and SADP products and plans. Products or plans with rules that differ from this base set of issuer business rules are defined at the product or plan level on the subsequent rows starting at row 11. If there are products or plans with rules which differ from those entered on row 10, starting at row 11, enter or select the following information in the columns listed below for each row.

   Note for SERFF Submitters: The HIOS system only allows one set of issuer-level business rules (row 10). If an issuer submits two templates (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different issuer-level business rules (row 10), the last template uploaded by the state from SERFF into HIOS will apply to all plans, both Individual Market and SHOP, unless the product or plan is listed separately. The issuer-level rules (row 10) submitted on the first template uploaded will be overwritten by the issuer-level rules (row 10) submitted on the second template uploaded. In order to avoid problems connected with issuer-level rule over-writes in SERFF, all Business Rules Template issuer-level business rules (row 10) should be the same. Products and plans which do not adhere to the business rules described at the issuer level (row 10) should be further described in the rows below row 10 as described below.

   a. *Product ID* (optional). For products with rules which differ from those entered on row 10, enter the 10-character (xxxxxSTxxx) HIOS generated Product ID number that identifies the product that will be associated with the rules defined in that row.

      i. If a Product ID is entered, then the rules defined in that row will be applied to all plans associated with that Product ID. All other plans and products will use the rules associated with either the Issuer ID in row 10 or different Product ID rule.

      ii. If no Product ID is entered, the rules associated with the Issuer ID in row 10 will be used for all products.

   b. *Plan ID (Standard Component)* (optional). Enter the 14-character Plan ID (xxxxxSTxxxxxxx) that identifies the plan that will be associated with the rules defined in that row.

      i. If a Plan ID is entered, then the rules defined in that row will be applied to that Plan ID only. All other plans and products will use the rules associated with the Issuer ID rule, Product ID rule or different Plan ID rule.

ii. If no Plan ID is entered, then the rules for the Product ID associated with that Plan ID will be used for all plans. If no Product ID rules were entered, the rules associated with the Issuer ID in row 10 will be used for all products and plans.

4. *How are rates for contracts covering two or more enrollees calculated?* (required). Select from the drop-down menu one of the following two options:

   a. ***There are rates specifically for couples and for families (not just addition of Individual rates)***—Use this selection if you are a QHP issuer in a state that does not permit rating for age or tobacco use, or if you are an Individual Market SADP issuer in any state. Health insurance issuers in states that require community rating must determine premiums for family coverage by using uniform family tiers and the corresponding multipliers established by the state.

      Note for SHOP Issuers: Please do not make this selection for FF SHOP (Federally-facilitated Small Group Health Options Program) or SP SHOP (State Partnership Small Group Health Options Program) products or plans. In order to display any FF SHOP or SP SHOP on-exchange plans, select the option of "A different rate (specifically for parties of two or more) for each enrollee is added together." This applies to both QHPs and SADPs.

   b. ***A different rate (specifically for parties of two or more) for each enrollee is added together***—Use this selection if you are a QHP issuer (except those in pure community rated states with uniform family tiers and corresponding multipliers) or a SHOP issuer. Premium rates are calculated by adding the per-member rates and providing the sum. Individual Market SADP issuers may also use individual rating if allowed by the state.

5. *What are the maximum number of underage (under 21) dependents used to quote a two-parent family?* (required). (Note: a two-parent family consists of a primary and secondary subscriber and their dependents. Specific questions about secondary subscribers are found below at items 9 and 10.) Select the maximum number of under age (under 21) dependents from the drop-down menu:

   a. **1**—Select if the maximum number of covered children under age 21 used to calculate a rate is 1.

      i. If one or more children under age 21 are in the Marketplace enrollment group, only the individual rate of the oldest child is included in the premium calculation, if rates are calculated individually.

      ii. If one or more children under age 21 are in the Marketplace enrollment group, only the couple plus child family tier rate will be returned in a state with uniform family tiers.

   b. **2**—Select if the maximum number of children under age 21 used to calculate a rate is 2.

i. If two or more than two children are in the Marketplace enrollment group, only the individual rates of the two oldest children are included in the premium calculation if rates are calculated individually.

ii. If two or more than two children are in the Marketplace enrollment group, only the couple plus two child family tier rate will be returned in a state with uniform family tiers.

c. **3 or More**—Select if the maximum number of children under age 21 used to calculate a rate is 3 or more.

i. If three or more children are in the Marketplace enrollment group, only the individual rates of the three oldest children are included in the premium calculation if rates are calculated individually.

ii. If three or more children are in the Marketplace enrollment group, only the couple plus three child family tier rate will be returned in a state with uniform family tiers.

d. Market rules state that only the three oldest covered children under age 21 are taken into account in determining the total family premium. This question allows an issuer to set the maximum at fewer than three.

e. For dental plans only. SADPs that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating factors not present in this template, increase the maximum number of children rated on a single contract, or to remove this maximum altogether. In the *Plan Attributes* section of the Plans & Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments. The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that on-exchange FF SHOP and SP SHOP SADPs may not use estimated rates, and must have guaranteed rates in order to be offered on-exchange.

f. For pediatric dental plans only. This field is not applicable to pediatric-only stand-alone dental plans. Any selection is valid for this type of plan and will not affect eligibility or rating. Please note that no pediatric-only FF SHOP or SP SHOP SADPs may be offered on-exchange.

6. *What are the maximum number of underage (under 21) dependents used to quote a single parent family?* (required). Select the maximum number of children under age 21 from the drop-down menu:

   a. **1**—Select if the maximum number of children under age 21 used to calculate a rate is 1.

      i. If one or more children under age 21 is in the Marketplace enrollment group, only the individual rate of the oldest child is included in the premium calculation, if rates are calculated individually.

      ii. If one or more children under age 21 is in the Marketplace enrollment group, only the parent plus child family tier rate will be returned in a state with uniform family tiers.

   b. **2**—Select if the maximum number of children under age 21 used to calculate a rate is 2.

      i. If two or more children are in the Marketplace enrollment group, only the individual rates of the two oldest children are included in the premium calculation if rates are calculated individually.

      ii. If two or more children are in the Marketplace enrollment group, only the couple plus two child family tier rate will be returned in a state with uniform family tiers.

   c. **3 or More**—Select if the maximum number of children under age 21 used to calculate a rate is 3 or more.

      i. If three or more children are in the Marketplace enrollment group, only the individual rates of the three oldest children are included in the premium calculation if rates are calculated individually.

      ii. If three or more children are in the Marketplace enrollment group, only the couple plus three child family tier rate will be returned in a state with uniform family tiers.

   d. Market rules state that only the three oldest covered children under age 21 are taken into account in determining the total family premium. This question allows an issuer to set the maximum at fewer than three.

   e. For dental plans only. SADPs that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating factors not present in this template, increase the maximum number of children rated on a single contract, or remove this maximum altogether. In the *Plan Attributes* section of the Plans & Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments. The plan display will then indicate to

consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that on-exchange FF SHOP and SP SHOP SADPs may not use estimated rates, and must have guaranteed rates in order to be offered on-exchange.

f. For pediatric dental plans only. This field is not applicable to pediatric-only SADPs. Any selection will be valid for this type of plan and will not affect eligibility or rating. Please note that no pediatric-only FF SHOP or SP SHOP SADPs may be offered on-exchange.

7. *Is there a maximum age for a dependent?* (required). Allows the issuer to set the maximum age for a child for purposes of eligibility:

   a. **Yes**—If selected, a pop-up will appear allowing the issuer to enter the maximum age with a default value of 21 or higher. QHP issuers must enter a minimum value of 25. SADP issuers must enter a minimum value of 21. Please note that the age entered is inclusive *through* that age. For example, a value of 25 is through age 25, up to age 26.

   b. **Not Applicable**—If selected, then there is no maximum age and the dependent is allowed to enroll regardless of age as long as they meet the other eligibility rules.

   c. Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26.[1]

   d. Dental plans are not subject to the minimum dependent age of 25, and may have a dependent age as low as 21.

   Note: Maximum age for dependent only applies to the dependent relationships of Child, Adopted Child, Foster Child, and Stepson or Stepdaughter.

8. *What are the maximum number of children used to quote a children-only contract?* (required). Select the maximum number of children allowed to be rated on a child-only plan:

   a. **1**—Select if the maximum number of children used to calculate a rate is 1.

      i. If one or more children are in the Marketplace enrollment group, only the individual rate of the oldest child is included in the premium calculation, if rates are calculated individually.

   b. **2**—Select if the maximum number of children used to calculate a rate is 2.

      i. If two or more children are in the Marketplace enrollment group, only the individual rates of the two oldest children are included in the premium calculation if rates are calculated individually.

[1] 45 CFR 147.120.

c. **3 or More**—Select if the maximum number of children used to calculate a rate is 3 or more.

   i. If three or more children are in the Marketplace enrollment group, only the individual rates of the three oldest children are included in the premium calculation if rates are calculated individually.

d. Market rules state that only the three oldest covered children under age 21 are taken into account in determining the total family premium. This question allows an issuer to set the maximum at fewer than 3.

e. For dental plans only. Stand-alone dental plans that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating factors not present in this template, increase the maximum number of children rated on a single contract, or remove this maximum altogether. In the *Plan Attributes* section of the Plans and Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments. The plan display will then indicate to consumers whether the displayed stand-alone dental plan premium is a guaranteed rate or an estimated rate. Please note that on-exchange FF SHOP and SP SHOP SADPs may not use estimated rates, and must have guaranteed rates in order to be offered on-exchange.

f. For pediatric dental plans only. This field is not applicable to pediatric-only stand-alone dental plans. Any selection will be valid for this type of plan and will not affect eligibility or rating. Please note that no pediatric-only FF SHOP or SP SHOP SADPs may be offered on-exchange.

9. *Are domestic partners treated the same as secondary subscribers?* (required). Selection determines whether a Domestic Partner is allowed to be covered as a secondary subscriber. Please note that domestic partners are not differentiated by sex, and can be same-sex or opposite-sex:

   a. **Yes**—If selected, allows Domestic Partners to be considered a "two-parent household" (referred to in item 5 above) for rating and eligibility purposes. (Note: If "Yes" is selected, indicate "Life Partner" as an allowable relationship in item 13 below.)

   b. **No**—If selected, does not allow Domestic Partners to be considered a "two-parent household" (referred to in item 5 above) for rating and eligibility purposes. (Note: Issuers may choose to cover Life Partner as an eligible dependent relationship in item 13 below, even if domestic partners are not treated the same as secondary subscribers. The Life Partner will not count toward a "two-parent household" for rating and eligibility purposes.)

10. *Are same-sex partners treated the same as secondary subscribers?* (required). Selection determines whether a Same-Sex partner is allowed to be covered as a secondary subscriber:

    a. **Yes**—If selected, then the primary subscriber/same-sex partner will be treated as a "two-parent household" (referred to in item 5 above) for rating and eligibility purposes. (Note: If "Yes" is selected, indicate "Life Partner" as an allowable relationship in item 13 below.)

    b. **No**—If selected, then the primary subscriber/same-sex partner will not be treated as a "two-parent household" (referred to in item 5 above) for rating and eligibility purposes. (Note: Issuers may choose to cover Life Partner as an eligible dependent relationship in item 13 below, even if same-sex partners (other than spouses) are not treated the same as secondary subscribers. The Life Partner will not count toward a "two-parent household" for rating and eligibility purposes.)

11. *How is age determined for rating and eligibility purposes?* (required). Select how age is defined to determine if a consumer is eligible for a plan rate:

    a. **Age on effective date**—Return the rate based on the consumer's age on the effective date.

    b. **Age on January 1st of the effective date year**—Return the rate based on the consumer's age on January 1st of the effective date.

    c. **Age on insurance date (age on birthday nearest the effective date)**—Return the rate based on the consumer's age closest to the effective date of the plan.

    d. **Age on January 1st or July 1st**—Return the rate based on the following:

        i. If the date of enrollment is prior to July 1st, then use the age as of January 1st.

        ii. If the date of enrollment is after to July 1st, then use the age as of July 1st.

    e. Market rules require QHP plans to select option one, "Age on Effective Date," while dental plans may choose from any of the four options above.[2] Please note, in order to be offered on-exchange, FF SHOP and SP SHOP SADPs should indicate only "Age on Effective Date." No matter the entry, all FF SHOP and SP SHOP plans, both QHPs and SADPs, will be displayed based on "Age on Effective Date."

12. *How is tobacco status returned for subscribers and dependents?* (required). Select how to determine if the tobacco rate is returned when calculating rates. Options are:

    a. **No tobacco use for at least [x] months**—If selected, a pop-up will appear asking for the number of months to use to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than 6 months. Dental issuers

[2] 45 CFR 147.102(a)(I)(iii).

are not subject to the look-back period.[3] Please note that FF SHOP and SP SHOP plans will not recognize look-back periods other than 6 months. Rates will be tobacco or non-tobacco depending only upon whether an enrollee indicates that he/she is an active tobacco user within the last 6 months (tobacco rate) or not an active tobacco user within the last 6 months (non-tobacco rate). Additionally, if the enrollee indicates that he/she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used.

b. **Not Applicable**—If selected, then there are no separate tobacco and non-tobacco use rates.

c. If rates are calculated by adding up individual rates, then the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and the non-tobacco rate for individuals who qualify for the non-tobacco rate.

d. For states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, there are no separate tobacco rates for each family tier.

13. *What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?* (required). Select from the pop-up list what relationships are allowed to be included when returning rates and if the relationship must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of either the primary or dependent. Please note that the FF SHOP and SP SHOP do not differentiate between dependents who live with the primary subscriber and those who do not.

    a. Type of Relationship is based on the 834 relationship list and includes the following:

        - Spouse*
        - Father or Mother
        - Grandfather or Grandmother
        - Grandson or Granddaughter
        - Uncle or Aunt
        - Nephew or Niece
        - Cousin
        - Adopted Child*

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

- Foster Child*
- Son-in-Law or Daughter-in-Law
- Brother-in-Law or Sister-in-Law
- Father-in-Law or Mother-in-Law
- Brother or Sister
- Ward*
- Stepparent
- Stepson or Stepdaughter*
- Self*
- Child*
- Sponsored Dependent
- Dependent of a Minor Dependent
- Ex-Spouse
- Guardian
- Court Appointed Guardian
- Collateral Dependent
- Life Partner*
- Annuitant
- Trustee
- Other Relationship*
- Other Relative

* Please note that for the FF SHOP and SP SHOP, only Spouse, Adopted Child, Foster Child, Ward, Stepson or Stepdaughter, Self, Child, Life Partner and Other Relationship are accommodated.

b. For each relationship, select "Yes" or "No" if the dependent is required to live in the same household:

   i. **Yes**—The dependent must live in the same household in order to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed.

   ii. **No**—The dependent may live in or outside of the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. Please note that the FF SHOP and SP SHOP do not differentiate between dependents who reside with the primary subscriber and those who do not.

   iii. Market rules require QHP issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26, regardless of support, residency or dependency factors.

   iv. QHP products and plans that cover children must select a value of "No" for whether the child dependent is required to live in the same household. This requirement applies for all child dependent relationships including Child, Adopted Child, Foster Child, and Stepson or Stepdaughter.

c. Select the relationship "Life Partner" to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Please note that relationships are not differentiated by sex. If an individually rated plan covers Spouses and Life Partners, same-sex and opposite sex Spouses and Life Partners are covered.

4.2.2 Finalizing Template

Once you have completed the Business Rules Template, follow these steps to finalize the template:

1. Click the **Validate** button in the top left of the template. The validation process will identify any data issues that need to be resolved. If no errors are identified proceed directly to the 3rd step.

2. If the template has any errors, a Validation Report will appear within a pop-up box indicating 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. Once the template is valid, proceed to the next step.

3. Click the **Finalize** button in the template. The **Finalize** function creates the XML file of the template that you need to upload in the applicable QHP Application System.

4. **Save** the XML template. It is recommended you save the validated template to your computer as both a standard Excel.XLSM file, and the finalized.XML file on your local computer in the same folder that contains the template.

5. Upload the saved file in the Business Rules section of the Rating Module of the QHP Application System.

4.3 Supporting Documentation Instructions

There are no supporting documents for the Business Rules section.