

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Center for Consumer Information and Insurance Oversight  
200 Independence Avenue SW  
Washington, DC 20201



## **OVERSIGHT GROUP**

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Date: March 24, 2017

To: Health Insurance Issuers in Missouri, Oklahoma, Texas, and Wyoming

RE: Form and Rate Filing Instructions and Health Insurance Oversight System (HIOS)  
Technical Assistance for Plan Year 2018

The Centers for Medicare & Medicaid Services (CMS) is responsible for enforcing provisions of title XXVII of the Public Health Service Act (PHS Act) with respect to health insurance issuers in the group and individual markets when a state informs CMS that it does not have authority to enforce or is not otherwise substantially enforcing one or more of the provisions. In addition, if a state does not have an Effective Rate Review Program, CMS will review individual and small group rate increases subject to review to determine whether the increase is unreasonable, as required by 45 CFR Part 154. Within CMS, the Oversight Group in the Center for Consumer Information & Insurance Oversight (CCIIO) is primarily tasked with these duties.

### **Form Filing Instructions**

#### **1. Who must submit form filings to CMS for Plan Year 2018?**

Health insurance issuers in Missouri, Oklahoma, Texas, and Wyoming must submit form filings for all products in the individual<sup>1</sup> and group markets, except for excepted benefit products (such as stand-alone dental products) and grandfathered products.

Issuers offering products for which they are not applying for Qualified Health Plan (QHP) certification must submit form filings only if the forms associated with the product were changed from prior plan years in a manner that requires re-filing the plans with the State Department of Insurance under applicable state requirements.

#### **2. What is the difference between a product and a plan?**

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<sup>1</sup> Student health and accident plans are defined as individual market plans and are subject to these requirements.

A product is a discrete package of health insurance coverage benefits that are offered using a particular product network type within a service area.

A plan is the pairing of the health insurance coverage benefits under the product with a particular cost sharing structure, provider network, and service area. Plans within a product may vary with respect to cost-sharing amounts, provider network, and service area.<sup>2</sup> Plans within a product may not vary with respect to which benefits are offered.

### **3. How are form filings submitted?**

Forms must be submitted in the Health Insurance Oversight System (HIOS) Document Collection Form Filing Module at <https://portal.cms.gov>.

One product submission in the HIOS Document Collection Form Filing Module comprises all of the plans offered with the same product network type and identical benefits. Each product must be submitted separately. Each product submission must include all plans to be offered for that product.<sup>3</sup>

### **4. When is the form filing submission deadline?**

- May 10, 2017: Form filing window opens.
- June 21, 2017: Deadline for filing forms for all products, except for student health products and products offered in the large group market.
- 60 days prior to marketing: Deadline for filing forms for student health products and products offered in the large group market.

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<sup>2</sup> The combination of all service areas of the plans offered within a product constitutes the total service area of the product.

<sup>3</sup> A product submission may include QHPs and Non-QHPs.

## 5. What's new this year?

- a. The Form Filing module has been updated to allow the ability to add or remove products after the product submission is initially confirmed. Once the appropriate product changes have been made, the user must follow the established workflow of saving and confirming submission. Issuers will not be able to add or remove products once review is underway.
- b. An optional review checklist is available for reference during the preparation and submission of forms. This checklist identifies a number of PHS Act provisions that are used during form filing review. It does not provide an exhaustive or all-inclusive list of provisions that may be used during the review. Issuers are invited to review this checklist while preparing forms for submission. The checklist is located on the Announcements page of the HIOS Document Collection Form Filing Module.

## 6. What documents must be submitted in the HIOS Document Collection Form Filing Module?

Please reference the table below to determine which forms must be filed in the HIOS Document Collection Form Filing Module. There are additional requirements specific to QHP certification that are required by QHP Plan Management as stated in the Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces<sup>4</sup>, such as the Plan & Benefit Templates and prescription drug templates. Completed templates and justifications must be uploaded into the HIOS Plan Management and Market Wide Functions Module.<sup>5</sup>

Form	QHP	Non-QHP <sup>6</sup>	Large Group
Group master policy <sup>7</sup>	Required	Required	Required
Evidence of coverage or policy forms	Required	Required	Required
Schedule of benefits for each plan and silver plan variation	Required	Required	Required
Schedule of benefits for each cost-sharing reduction plan variation	Required	Not required	Not required

<sup>4</sup> Addendum to 2018 Letter to Issuers in the Federally-facilitated Marketplaces, available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf>

<sup>5</sup> Templates are available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/ghp.html>.

<sup>6</sup> Student health and accident plans are defined as individual market plans, and are subject to these requirements.

<sup>7</sup> For group market product submissions only.

<b>Form</b>	<b>QHP</b>	<b>Non-QHP<sup>6</sup></b>	<b>Large Group</b>
Summary of Benefits and Coverage (SBC) <sup>8</sup>	One required per network type	One required per network type	One required per network type
Notices of appeals and external review rights	Required	Required	Required
Riders, endorsements, and amendments <sup>9</sup>	If applicable	If applicable	If applicable
Plan & Benefits Template	Not required	Required	Not required
CMS Prescription Drug Template (one per product in Excel format)	Not required	Required	Not required
Results of the Actuarial Value Calculator (screen shot or in Excel format)	Not required	Required	Not required
Unique Plan Design Supporting Documentation and Justification	Not required	If applicable	Not required
EHB Substituted Benefit (Actuarial Equivalent) Justification	Not required	If applicable	Not required
Formulary—Inadequate Category/Class Count Supporting Documentation and Justification	Not required	If applicable	Not required

<sup>8</sup> One SBC per network type will be reviewed. Do not submit more than one SBC per product submission. For a product submission that includes plans designed to comply with metal level actuarial value requirements, submit a SBC for a silver level plan.

<sup>9</sup> Riders are not permitted for plans that are subject to the single risk pool requirements.

## 7. What are some general tips for submitting forms?

- a. During the submission process, identify whether each product submission will include any plans submitted for QHP certification, and, if applicable, identify the coverage level for each plan within a product (i.e., bronze, silver, gold, platinum, or catastrophic).
- b. If a form is used for multiple products or plans, indicate which forms belong with which products or plans. This includes identifying whether multiple product submissions use identical Rx templates as other product submissions.
- c. Issuers are invited to upload redlined versions of forms that reflect changes from prior product submissions, or changes made to the product submission as a result of an issue notice.
- d. Issuers that submit product submissions with variable documents must include any explanations of variability as part of the submission.
- e. Each file should be labeled with the appropriate name for identification (e.g., “RxtemplateQHP.xls” or RxJustificationQHP.xls”). The following are examples of acceptable Document Type fields:

- Contract – Group master policy or individual policy form
- Contract Amendment – Amendments to the group master policy or individual policies
- Policy Forms – Schedules of benefits
- Certificates/Outlines of Coverage – Evidences of coverage
- SBC – Summary of Benefits and Coverage
- Supplemental Information – Plan & Benefits Template, explanations of variability, certifications, explanations, submission letters
- Rx Template – Pharmacy template
- AV Calculator – AV Calculator screenshots
- Justification – Unique Plan Design supporting documentation and justification, Essential Health Benefit substituted benefit justification, Formulary – Inadequate Category/Class Count supporting documentation and justification
- Policy Riders & Endorsements – Benefit riders, or endorsements, or amendments
- Notice Requirements – Notices of appeals and external review, and required federal notices

If a document is submitted in connection with a QHP certification application, indicate that the document is to be used in a QHP in the file name. For example: “CertXXX\_MO\_2018\_Silver\_QHP”.

## 8. What were the most common issues found for Plan Year 2017 and how can issuers avoid them?

The most common issues occurred when issuers included language pulled directly from the EHB-benchmark plans. Please note that EHB-benchmark plans may not be compliant with all PHS Act requirements. Common issues in EHB-benchmark plans include:

- **Discriminatory benefit designs.** Any age limit on a benefit (or any other reduction in the generosity of a benefit in some manner for subsets of individuals) may be identified as a potentially discriminatory benefit design. Any such limitation is expected to be based on clinical guidelines and medical evidence that supports the reduction of that benefit.<sup>10</sup> Issuers may be asked to submit a justification that provides such clinical guidelines and medical evidence.
  - For example, a limit on coverage for the treatment of a congenital defect for those above the age of 19 are expected to be accompanied by a justification based on clinical guidelines and medical evidence that explains why coverage is not appropriate for those above the age of 19. Any justification that simply asserts that the EHB-Benchmark plan places a similar age limitation on the service, or that the limitations are part of a state mandated benefit, will not be accepted.
- **Essential Health Benefits.** Non-grandfathered small group and individual market insurance coverage must provide coverage of benefits in the ten EHB categories. Coverage of EHBs must be substantially equal to such coverage in the state's EHB-Benchmark plan, including all limitations and exclusions on the benefits.<sup>11</sup> Provide substitution information and actuarial justification to explain any variances from the EHB-Benchmark plan.
- **Dollar Limits.** Lifetime and annual dollar limits are not permitted on EHBs, regardless if the EHB-Benchmark plan imposes such limits.<sup>12</sup> HHS regulations do not prohibit converting annual dollar limits to actuarially equivalent service or treatment limits.<sup>13</sup>

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<sup>10</sup> 80 FR 10749 at 10823 (2016 Payment Notice (Feb. 27, 2015))

<sup>11</sup> 45 CFR §§ 147.150 and 156.115(a)(1)(i) and (ii)

<sup>12</sup> 45 CFR § 147.126

<sup>13</sup> Frequently Asked Questions on the Essential Health Benefits Bulletin, February 17, 2012, Q.9, available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>

- **Rx Template class count and non-discrimination reviews** (if applicable). Run the Rx Class Count tool and the Non-discrimination tool against the Rx template (2017, v 6.0) to ensure there are no discrepancies. If there are discrepancies, provide a detailed justification form to explain which drugs are used in the category or why the plan design is not discriminatory. The Rx review tools are available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html>.

## **9. Is CMS offering additional opportunities to ask questions about Form Filing?**

The Oversight Group will host a conference call on April 3, 2017, at 11:00am Eastern to provide issuers with an opportunity to ask questions pertaining to filing forms and rates with CMS for review. No registration is required. Issuers may submit questions in advance to [formfiling@cms.hhs.gov](mailto:formfiling@cms.hhs.gov).

On April 3, 2017, at 11:00am Eastern, please call 1-877-267-1577 with conference number 994 735 772 to access the conference call.

## **10. How do I use HIOS to submit a Form Filing?**

The Document Collection Form Filing Module within HIOS is the federal document collection repository for form filing submissions. A copy of the HIOS Document Collection Form Filing Module Technical Guide is available for download upon access of the Document Collection Form Filing Module.

Issuers will need to register for access to HIOS, request access to the Document Collection Form Filing Module, and choose the user role for their submission. One of the two mutually exclusive user roles must be selected: (1) Submitter, who completes the application and submits the documents, or (2) Certifying Official, who provides certification to select Submitter users with permission to confirm application submissions to CMS for review.

a. New HIOS users:

i. Register for a CMS EIDM Account

1. Navigate to the CMS Enterprise Portal (<https://portal.cms.gov>) and select “New User Registration” on the right side of the page.
2. Accept the Terms and Conditions.
3. Enter the required personal information and choose the desired User ID and Password. The User ID uniquely identifies the user to EIDM, and therefore cannot be changed. Based on the information provided, users will be required

to answer questions for identity verification. This information is submitted to Experian and unique questions and answers are provided for identity proofing. After completing the registration process, an email acknowledging successful registration to EIDM will be sent to the user, along with the User ID.

ii. Register for a HIOS Account:

1. Navigate to the CMS Enterprise Portal (<https://portal.cms.gov>) and select the 'Login to CMS Secure Portal' button.
2. Accept the Terms and Conditions.
3. Enter your EIDM User ID and Password and select the 'Log In' button.
4. On the My Portal page, select the 'Request Access Now' button.
5. From the Access Catalog, select the 'Request Access' button for the HIOS application.
6. On the My Access page, select the 'Request New System Access' link. Select 'HIOS Application' from the System Description drop-down menu and 'HIOS User' for the Role.
7. On the Request New System Access page, select the hyperlink provided to register for access to HIOS. On the Request HIOS Account page, complete the HIOS registration form and submit for approval. Once the HIOS user registration request has been reviewed and approved, you will receive an email containing the HIOS Authorization Code.
8. Repeat steps 1-6 above. On the Request New System Access page, enter the HIOS Authorization Code and then select the 'Submit' button.
9. The system will take you through the identity verification process. Accept the Terms and Conditions and proceed with the on-screen instructions to verify your identity. Once you complete the questions and answers on the Verify Identity screen, select the 'Next' button.
10. Users will see an on-screen message confirming successful remote identity proofing. Select the 'Next' button and proceed to Multi-Factor Authentication (MFA). Please refer to the next section in this guide for step-by-step instructions on how to register an MFA device.

iii. Register an MFA Device (For New Users)

After successful completion of the identity verification process, new users will be prompted to complete the registration of a device for Multi-Factor Authentication.

1. On the Multi-Factor Authentication Information page, select the 'Next' button to proceed with MFA device registration.

2. Select an MFA device from the 'MFA Device Type' drop-down. Follow the on-screen instructions for your selected device type to complete the registration.
3. You will see an on-screen message confirming successful registration of the device to your user profile. Select the 'OK' button. This completes the MFA device registration process. Select 'Log Out' to exit the CMS Portal.

iv. Login Using MFA

1. Navigate to the CMS Enterprise Portal (<https://portal.cms.gov>) and select the 'Login to CMS Secure Portal' button.
2. Accept the Terms and Conditions.
3. Enter your User ID and select the 'Next' button.
4. Enter your Password and select the MFA Device Type. Enter the Security Code from your MFA device and select the 'Log In' button.
5. You will see a yellow 'HIOS' button on the top left of the dashboard. Select the yellow 'HIOS' button.
6. On the landing page, select the 'Access HIOS' link to access HIOS functionality.

v. HIOS Organization Registration

1. Select the 'Manage an Organization' button on the HIOS Home Page.
2. On the Manage an Organization page, select 'Create new organization' from the drop-down menu.
3. Select the Organization Type. There is a hyperlink to a list of organization types and their definitions to help you decide which organization type to create. Provide a Federal EIN/TIN to conduct a search to determine if the organization currently exists in HIOS. If the organization does not have an FEIN, select 'Other Organization Type' from the drop-down list and check the box, 'My organization does not have an FEIN'. Enter the organization name and select the 'Organization Search' button.
4. If an organization does not exist, you will need to register the new organization by selecting the 'Create Organization' button. On the Register New Organization page, enter your organization's information and select the 'Continue' button.
5. On the Register Attributes for New Organization page, enter your organization's attribute information and select the 'Review/Continue' button. Review your organization information and then select the 'Submit' button.

6. You will see a confirmation message notifying you to log back in to HIOS within 1-2 business days to check the status of your request. Select the 'Continue' button to navigate back to the Manage an Organization page.

b. Existing HIOS Users

i. HIOS Role Management

Users with an organizational association can request a role(s) for the HIOS module(s).

1. Select the 'Role Management' button on the HIOS Home Page.
2. Select the 'Request Role' tab. On the Request Role page, there's a hyperlink to a description of each module and the role functionality.
3. Select from the Module drop-down menu.
4. Select the Requested Role, User Type, User Sub-Type (if applicable to the module). You will be prompted to select an Association.
5. Enter the HIOS Issuer ID and select the 'Search' button.
6. Select the 'Add Issuer' button to associate the role to multiple Issuers per request. The system allows up to 10 Issuers per submission.
7. Proceed to submit the role request. You will see a confirmation message notifying you to log back in to HIOS within 1-2 business days to check the status of your request. To see your user role(s) and access permissions, select the 'View Existing Role' tab.

A copy of the HIOS Document Collection Form Filing Module Technical Guide is available for download once you access the Document Collection Form Filing Module in HIOS. Please note, submission for Large Group products may need to be added as a New Product. See the HIOS Document Collection Form Filing Module Technical Guide for instructions on how to add these products in the HIOS Form Filing Module. If you have any questions regarding accessing HIOS, please contact the help desk at [CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov) or 1-855-CMS-1515.

Operationally, the HIOS Document Collection Form Filing module only allows issuers to add products in the Large Group market; it prohibits issuers from adding products in the Individual/Small Group markets (an error message is displayed to the user). Users should continue adding Individual and Small Group market products within the HIOS Plan Finder Product Data Collection Module.

1. From the HIOS Portal, select “HIOS Plan Finder Product Data Collection Module” button.
2. Select the “View Issuer Submitted Data” tab.
3. Select the “Product Offering Report” link.
4. To create a new product, select the “Add New Product” link to get a blank product entry window. A new Product ID will be automatically generated once the user selects Submit.

## Rate Filing Instructions

### **1. For which plans must rate filings be submitted?**

Health insurance issuers filing in states that do not have an Effective Rate Review Program<sup>14</sup> are required to submit rate filings for new or renewal rates effective on or after January 1, 2018, for all non-grandfathered plans in either the individual or small group markets. Rate filings will be reviewed for compliance with the market reform rules under the PHS Act and the Affordable Care Act, including rating rules and the single risk pool requirements, as applicable.

### **2. What documents need to be submitted?**

Issuers of single risk pool plans<sup>15</sup> must submit a Rate Filing Justification into the HIOS Unified Rate Review (URR) Module which generally consists of Part I – Unified Rate Review Template (required for all rate filings), Part II – Written Description Justifying the Rate Increase (required for filings which include a plan with a rate increase of 10% or more), and Part III – Rate Filing Documentation (Actuarial Memorandum) (required for rate increases of any size).

Issuers of non-grandfathered student health plans and transitional plans must submit a Preliminary Justification for any rate increases of ten percent or greater into the HIOS Rate Review Justification (RRJ) Module which generally consists of Part I – Rate Increase Summary Form, Part II – Written Explanation of the Rate Increase, and Part III – Rate Filing Documentation. For any rate increases less than ten percent, issuers of non-grandfathered student health plans are required to submit into the HIOS RRJ Module Part I and Part III. In these instances, Part II is not required for filings where all plans have rate increases of less than ten percent, and issuers may make a statement to that effect in the Part II text box.

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<sup>14</sup> States which will not have an Effective Rate Review Program for the 2018 Plan Year are Oklahoma, Texas, and Wyoming. Therefore, CMS will review rate increases subject to review in these states to determine whether they are unreasonable, as required by 45 CFR Part 154.

<sup>15</sup> For purposes of the requirements established in 45 CFR Part 154, “single risk pool plan” is used to refer to non-grandfathered health insurance coverage in the individual or small group (or merged) market that is subject to all of the single risk pool provisions at 45 CFR § 156.80.

### **3. When do required documents need to be submitted?**

The rate filing documents for single risk pool plans (QHP and Non-QHP) must be submitted into the HIOS URR Module for states without an Effective Rate Review Program is no later than June 1, 2017.<sup>16</sup> For quarterly rate update submissions in the small group market, the deadline is 105 days prior to the effective date of the quarterly change. If the single risk pool includes a QHP offered in the Federally-facilitated SHOP, issuers should be mindful of the data correction windows when a revised Rates Table Template must be submitted. Data correction windows will be announced in advance, and CMS will provide detailed information on timelines and required submissions at that time.

The rate filing documents for non-grandfathered student health plans and transitional plans must be submitted in to the HIOS RRJ Module. Issuers are encouraged to submit the Preliminary Justification at least 60 days in advance of implementation of the rate increase.

### **4. When will CMS publish rate filing information<sup>17</sup> for 2018 benefit year single risk pool rates?**

CMS hopes to publish all applicable parts of the Rate Filing Justification for all proposed rates for single risk pool coverage (including both QHP and Non-QHPs), regardless of whether the product includes a plan with a rate increase that is subject to review on August 1, 2017.<sup>18</sup> The target date for CMS to post final rate information for single risk pool coverage is November 1, 2017.

### **5. What if issuers have questions about rate filing submissions?**

For questions regarding submission of rate filing documents, please contact the rate review team by email at [RateReview@cms.hhs.gov](mailto:RateReview@cms.hhs.gov).

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<sup>16</sup> This is the proposed revised date as reflected in the DRAFT Bulletin: Revised Timing of Submission and Posting of Rate Filing Justification for the 2017 Filing Year for Single Risk Pool Coverage (February 17, 2017) (hereinafter the February 17, 2017 DRAFT Bulletin), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-2017-filing-timeline-bulletin-2-17-17.pdf>. The February 17, 2017 DRAFT Bulletin was open for comment until March 7, 2017, and this date is therefore subject to change. *See also* the Key Dates: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance (February 17, 2017), available at: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Revised-Key-Dates-for-Calendar-Year-2017-2-17-17.pdf>.

<sup>17</sup> CMS will not post information that is trade secret or confidential commercial or financial information consistent with HHS' Freedom of Information Act regulations at 45 C.F.R. § 5.31(d).

<sup>18</sup> This is the proposed revised date as reflected in the February 17, 2017 DRAFT Bulletin and is subject to change. *See, supra* note 16.