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CCIIO/SEG

QUALIFIED HEALTH PLAN APPLICATION STATE REVIEW TOOLS

USER GUIDE: DATA ANALYSIS

Version 1.0

Change History Table

Version Number	Version Date	Summary of Changes
1.0	06/6/2013	Initial release, Version 1.0 (aligns with Version 2.0 of the QHP Application State Review Tools)

Table of Contents

QHP APPLICATION STATE REVIEW TOOLS USER GUIDE: DATA ANALYSIS

INTRODUCTION

The Qualified Health Plan (QHP) Application State Review Tools are a set of Excel-based evaluation services that states can use to evaluate QHP applications for compliance with Federal certification standards. The QHP Application State Review Tools are comprised of six tools: (1) Master Review Tool; (2) Formulary Tool; (3) Cost Sharing Tool; (4) Essential Community Provider (ECP) Tool; (5) Meaningful Difference Tool; and (6) Non-Discrimination Benefit Review Tool. The ability of a state to use the automated portions of these tools is contingent upon the state's use of the Federally developed standard data collection templates for its QHP applications (e.g., Plans and Benefits templates). The QHP Application State Review Tools are offered as one methodology for states performing plan management activities, regardless of Marketplace[1] model, to review each of the required standards.

This user guide follows *QHP Application State Review Tool User Guide: Loading the Data* and assists states that are using the QHP Application State Review Tools with review of QHP plans' compliance with certification standards. While *QHP Application State Review Tool User Guide: Loading the Data* leads state reviewers through loading and running the tools, this user guide explains how to analyze and validate the review tools output data and track the results.[2] It provides step-by-step instructions for reviewing each QHP certification standard in the Master Review Tool, including the process for validating results from stand-alone tools. The table below lists the QHP certification standards, indicates which standards can be evaluated by using the tools, and includes a list of the sources needed to perform each proposed review.

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
Accreditation	Ensure compliance with proposed accreditation timeline. Collect and verify information on issuers' existing accreditation during issuer application period for use in determining if QHP meets accreditation requirement.	✓		• Issuer Applications
Program Attestation	Accept issuer attestation of compliance with regulation (note that Marketplace Final Rule defers to existing state marketing laws) and conduct post-certification monitoring.	✓		• General Issuer Attestations

1 The QHP Application State Review Tools refer to Health Insurance Marketplaces as "Exchanges". This guide has been updated to be consistent with the current naming convention, Marketplaces, and thus the word "Exchanges" should be used interchangeably with the word "Marketplaces".

2 For assistance with loading plan data into the tools, please see *QHP Application State Review Tools User Guide: Loading the Data*.

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
SHOP Tying	Confirm issuer compliance with SHOP Tying Provision; if noncompliant, confirm satisfactory justification has been provided.	✓		• SHOP Tying Provision (45 CFR 156.200(g)) • Provider SHOP Tying Justifications
Essential Health Benefits Standards	Confirm that the plan being reviewed complies with standards for the provision of essential health benefits (EHB) consistent with Federal rules.	✓		• Plans and Benefits Templates OR • Form Filings
Essential Community Providers (ECP)	Collect issuer data on ECPs included in each network. Verify whether the issuer's network meets the regulatory standard consistent with Federally-facilitated Marketplace (FFM) policies and a reasonable interpretation of the regulation.	✓	✓	• Service Area Templates • ECP Templates • Plans and Benefits Templates
Formulary	Ensure compliance with EHBs and check for discrimination by counting drugs in each therapeutic category and class.	✓	✓	• Formulary Templates • Justification Documents
Actuarial Value and Cost Sharing Reductions	Verify that the QHP meets applicable actuarial value (AV) standards and cost-sharing reduction (CSR) requirements, consistent with Federal rulemaking.	✓	✓	• Unified Rate Review Templates • Plans and Benefits Templates
Meaningful Difference	Ensure QHP applications are "substantially different" from issuer's other applications so that consumers are not likely to have difficulty distinguishing among the issuer's offerings.	✓	✓	• Plans and Benefits Templates
Discriminatory Benefit Design	Conduct plan-level analyses targeting areas where discrimination would most likely occur, consistent with applicable regulations, to ensure that issuers do not employ benefit designs that discourage enrollment of individuals with significant health needs.	✓	✓	• Plans and Benefits Templates
Service Area	Verify that each service area meets geographic standards set forth in Exchange Final Rule and is non-discriminatory (e.g., service areas of at least an entire county).	✓		• Service Area Templates
Network Adequacy	Develop a process for evaluating network adequacy consistent with the Final Rule on the Establishment of Exchanges and Qualified Health Plans that includes one of the following operational procedures: current or proposed state network adequacy review, accepting attestation from an accredited issuer, or requiring issuer to submit a network adequacy plan.	✓		• Network Adequacy Section of QHP Application • Network Access Plan

QHP Certification Standard	Proposed Approach for Reviewing QHP Certification Standard	Master	Stand-Alone	Proposed Sources for Reviews
Licensure and Solvency	Verify licensure and good standing with state Department of Insurance (DOI) or collect documentation from issuer.			

USING THIS GUIDE

You may find it helpful to skim the guide to get a sense of the following characteristics:

- Items that appear in italics are *features*. E.g., "Open the ECP *Output* tab."
- Items that are in bold type are **functions**. E.g., "Select **Met**."
- For space considerations, screenshots of Excel worksheets may not include the full data picture.
- Each section of this user guide corresponds to a tab in the Master Review Tool. Tabs are ordered consistent with how they appear in the Master Review Tool.

QHP APPLICATION STATE REVIEW TOOLS OVERVIEW

Refer to the *QHP Application State Review Tools User Guide: Loading the Data* to see a list of all the documents and templates that were used to populate and run the Master Review Tool. The tools listed and described in the table below offer one methodology for reviewing the required standards. States may use all, none, or only portions of the review tools.

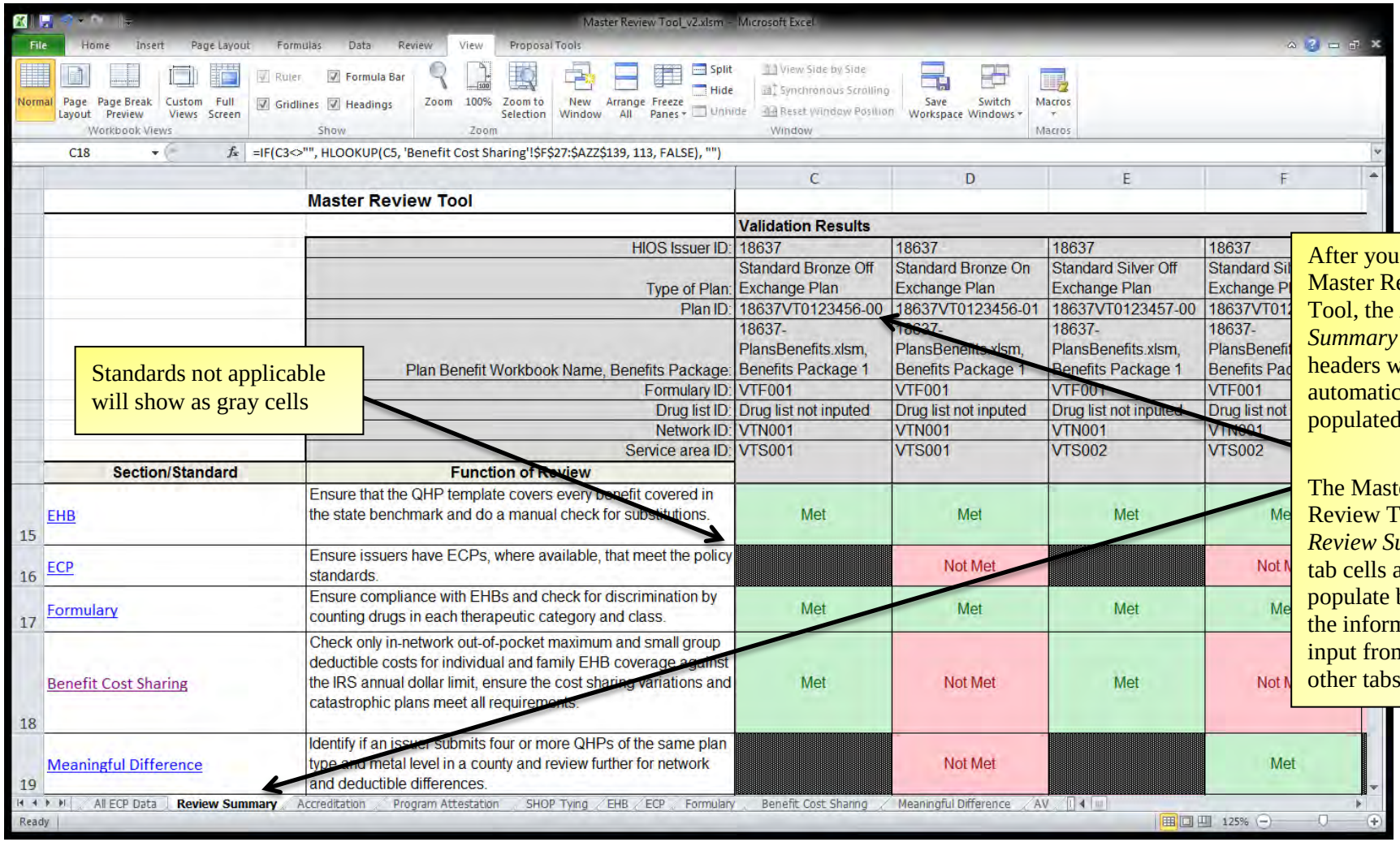
These tools can only be run for plans that are intended to be offered inside of the Marketplace, plans that are intended to be offered outside of the Marketplace, or for standard plans that are intended to be offered both inside and outside of the Marketplace. All of the review standards apply to plans that are inside the Marketplace, but not all of them apply to plans that are outside of the Marketplace. The Master Review Tool will grey out reviews when they are not applicable on the *Review Summary* tab, and plans offered outside of the Marketplace will not be listed on the tabs of the standards which are not applicable. The Non-Discrimination and Cost Sharing tools can be run for plans that are offered inside and outside the Marketplace, and the tools themselves contain further instructions on how to run them. The Formulary Tool can also be run for plans that are offered inside and outside the Marketplace, since it works at a drug list level, and hence works for all drugs lists regardless of which plans they are assigned to. The Meaningful Difference and ECP Tools are not to be used for plans outside of the Marketplace, since the Meaningful Difference and ECP standards only apply to plans that are inside of the Marketplace.

QHP Application Review Tool	Function
Master Review Tool	• Used to perform the reviews for several required standards. • Contains proposed step-by-step review processes for each standard. • Includes additional direction when a stand-alone tool (described below) may help with a particular review.
Essential Community Providers (ECP) Tool	• Calculates the total ECPs an issuer has in a service area. • Compares the total ECP number to the ECPs available in that service area.

QHP Application Review Tool	Function
	• Confirms if the percent of ECPs covered is above a given threshold.
Formulary Tool	• Assists in the drug counting service on Health Insurance Oversight System (HIOS). • Ensures that the drug count for each drug category and class meets or exceeds the state's benchmark. • Reviews for the greater of one in each U.S. Pharmacopeia (USP) Category/Class as well as the benchmark counts.
Cost Sharing Tool	• Conducts four cost-sharing standards analyses (when applicable to the specific plan): o Out-of-Pocket Maximum (OOPM) Review, o Small Group Deductible (SGD) Review, o Cost-Sharing Reduction (CSR) Review, and o Catastrophic Plan Review.
Meaningful Difference Tool	• Compares all plans an issuer offers to identify multiple, identical plans that are offered in the same counties.
Non-Discrimination Benefit Review Tool	• Cross-checks all state plans against predetermined benefits. • Determines coverage discrimination when a benefit has significantly higher copay or coinsurance, or a significantly lower quantitative limit than most other plans.

I. REVIEW SUMMARY

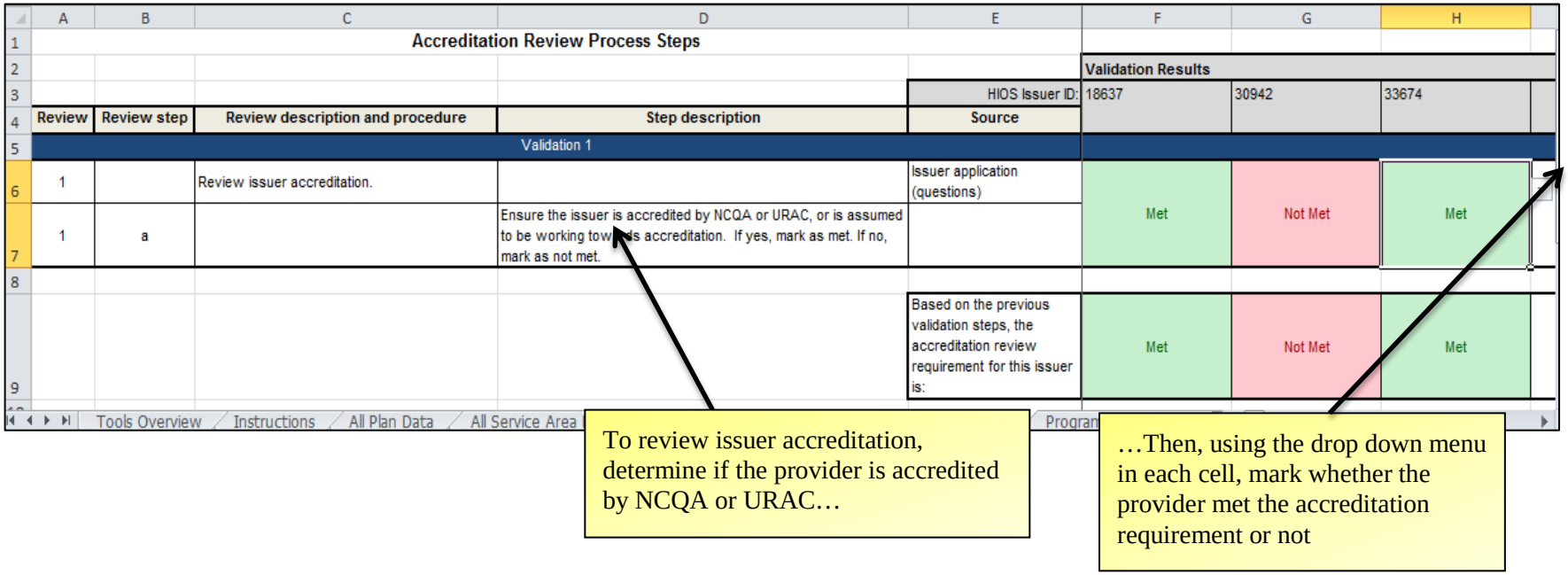
The Master Review Tool *Review Summary* tab tracks whether each plan has met its applicable QHP standards. You will not work directly in this tab as it auto-populates based on the information input from the other review tabs. The Master Review Tool is just one option for plan and issuer evaluation. State regulators may use the Master Review Tool *Review Summary* results as they see fit, regardless of whether a plan meets or does not meet its applicable standard(s).



II: ACCREDITATION REVIEW

The Accreditation review ensures that the issuer is accredited by the National Committee for Quality Assurance (NCQA) or URAC, or is working toward accreditation. Accreditation is reviewed at the issuer level rather than the plan level.

1. Review issuer accreditation to determine if the provider is accredited by NCQA or URAC using the issuer application and populate the Accreditation review (in the Master Review Tool *Accreditation* tab), with **Met** or **Not Met** accordingly.
2. As you complete the review for each issuer, the *Review Summary* tab will auto-populate the results for each plan.



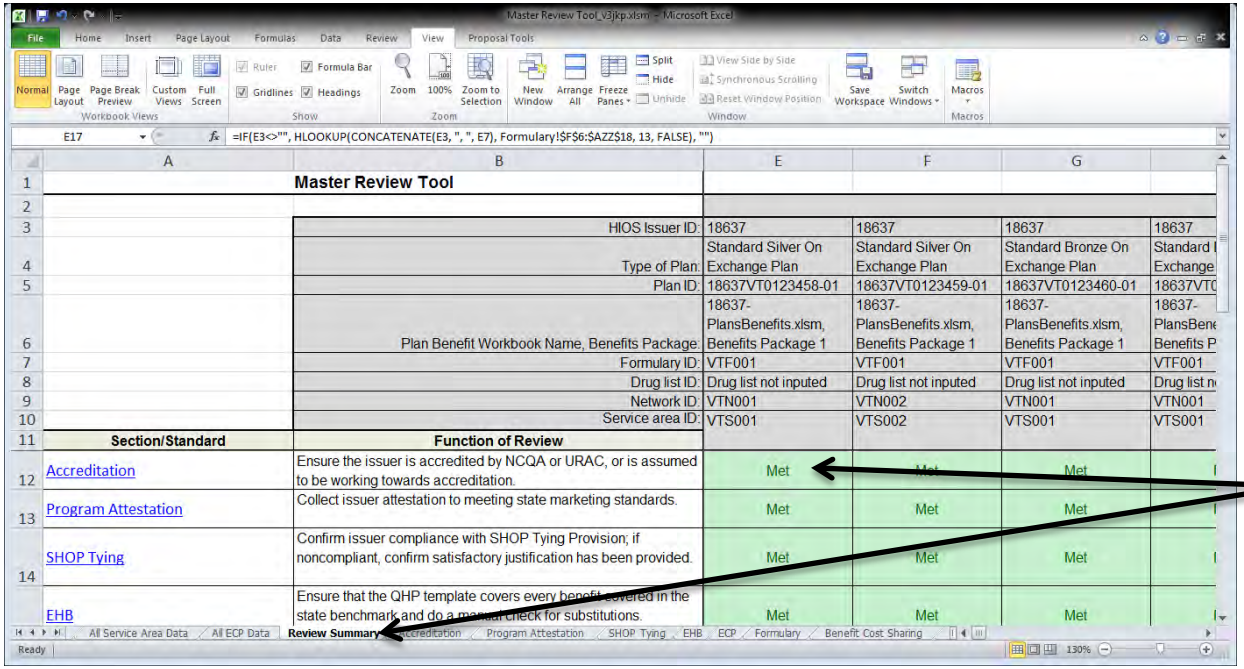
	A	B	C	D	E	F	G	H
1	Accreditation Review Process Steps							
2						Validation Results		
3					HIOS Issuer ID:	18637	30942	33674
4	Review	Review step	Review description and procedure	Step description	Source			
5	Validation 1							
6	1		Review issuer accreditation.		Issuer application (questions)	Met	Not Met	Met
7	1	a		Ensure the issuer is accredited by NCQA or URAC, or is assumed to be working toward accreditation. If yes, mark as met. If no, mark as not met.				
8								
9					Based on the previous validation steps, the accreditation review requirement for this issuer is:	Met	Not Met	Met

Tools Overview | Instructions | All Plan Data | All Service Area | Program

To review issuer accreditation, determine if the provider is accredited by NCQA or URAC…

…Then, using the drop down menu in each cell, mark whether the provider met the accreditation requirement or not

3. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Accreditation* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results

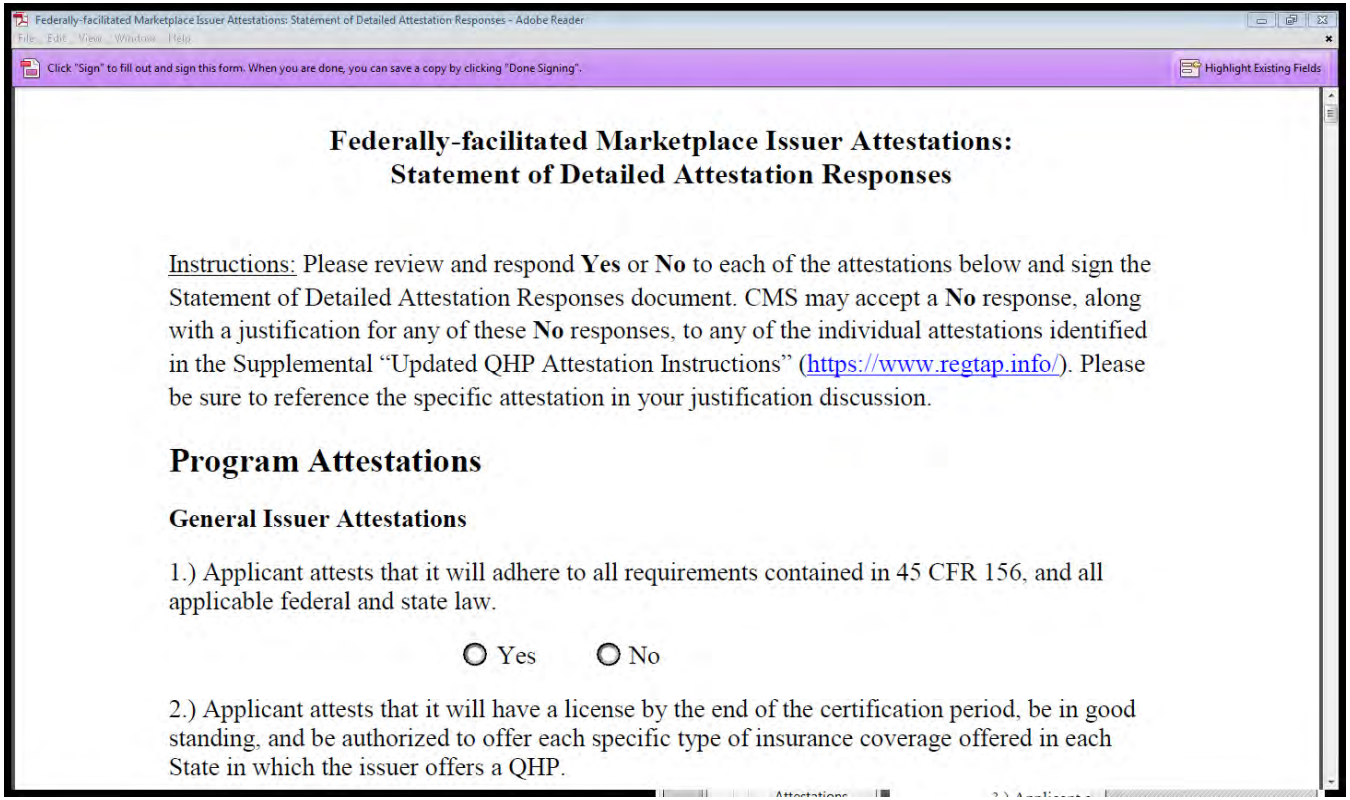


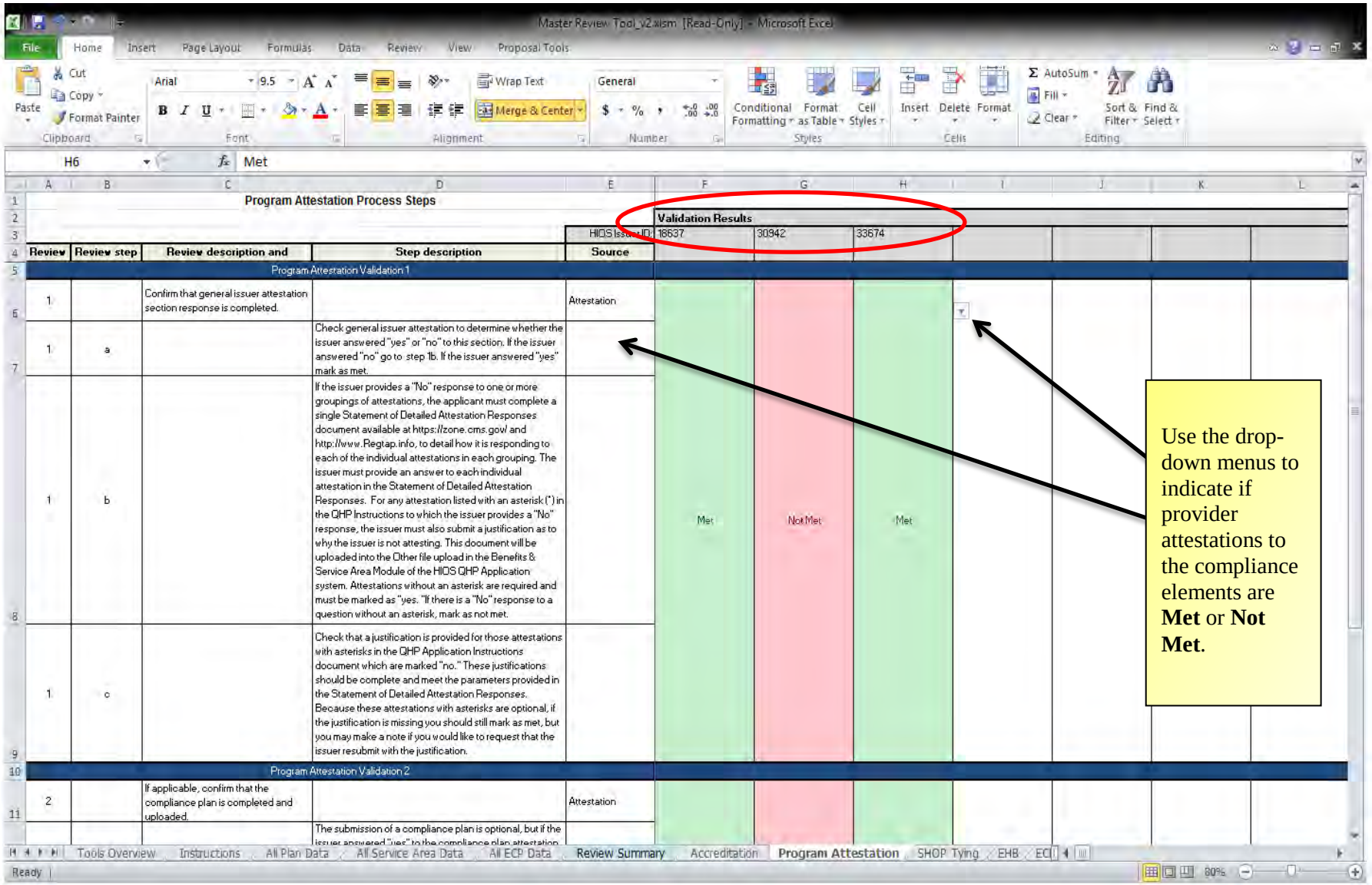
4. Save the Master Review Tool after you have completed the *Accreditation* review.

III: PROGRAM ATTESTATION REVIEW

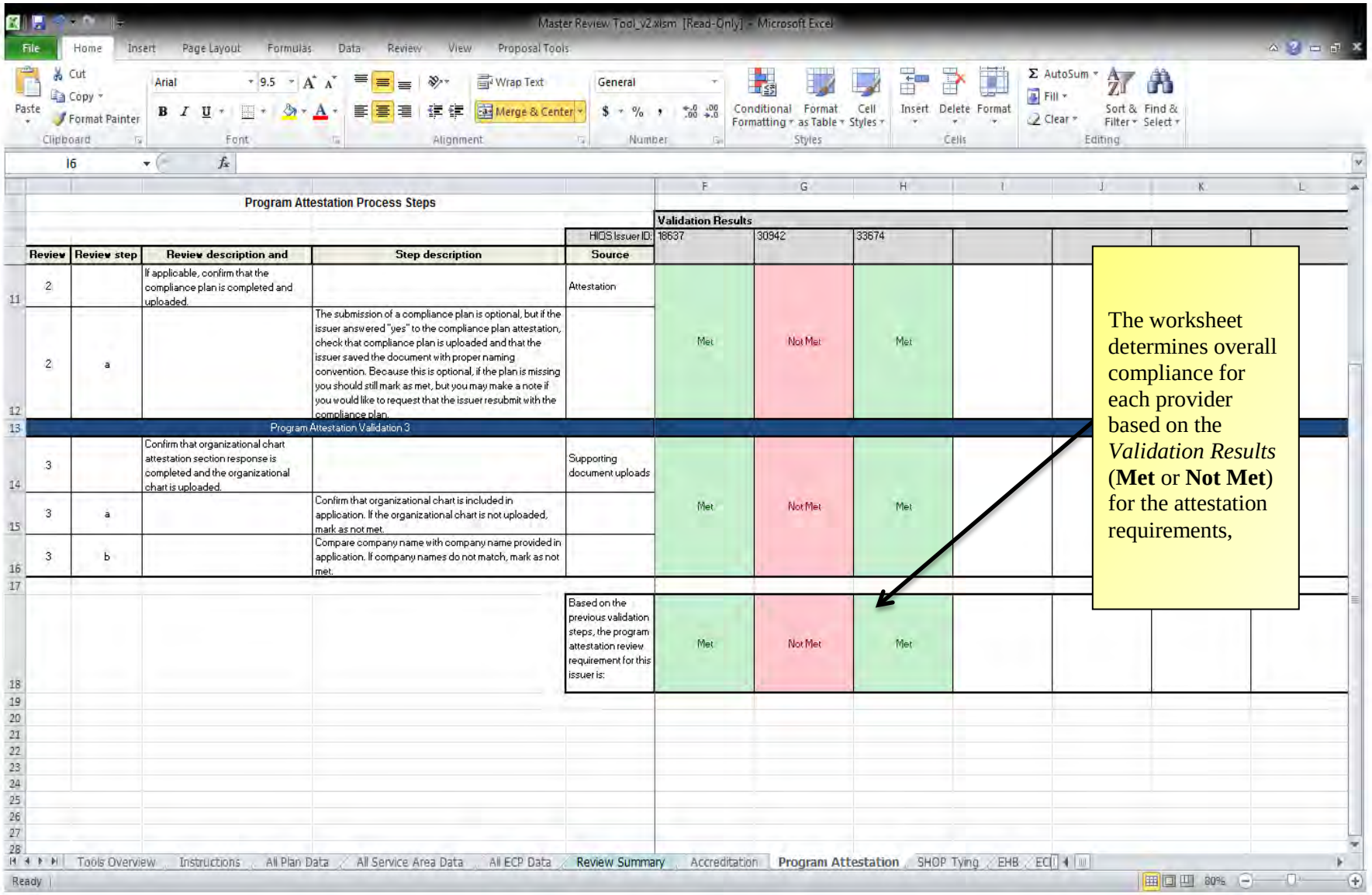
The *Program Attestation* review evaluates QHP applications for completed issuer attestation. The QHP instructions document for Program Attestations lists the attestations for which a "No" answer is acceptable.

1. **Use the General Issuer Attestation to populate the *Program Attestation* review** (in the Master Review Tool *Program Attestation* tab) for each issuer with **Met** or **Not Met**, accordingly.

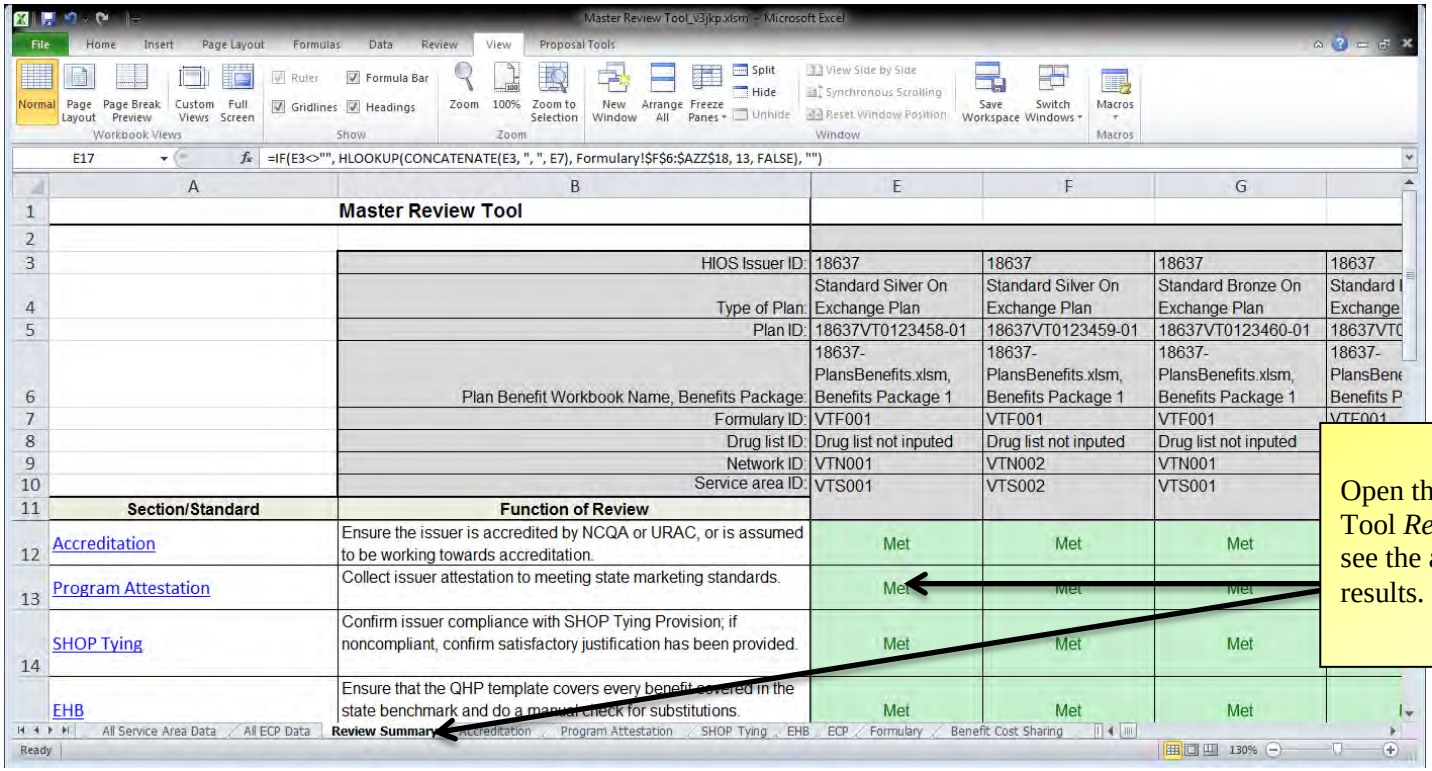




2. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the attestation requirements.



3. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Program Attestation* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



4. Save the Master Review Tool after you have completed the *Program Attestation* review.

IV: SHOP TYING REVIEW

1. **Use the SHOP Tying Provision (45 CFR §156.200(g)), the list of issuers subject to the SHOP Tying Provision , and the Provider SHOP Tying Justifications to complete the SHOP Tying review (in the Master Review Tool SHOP Tying tab) with Met or Not Met accordingly.**

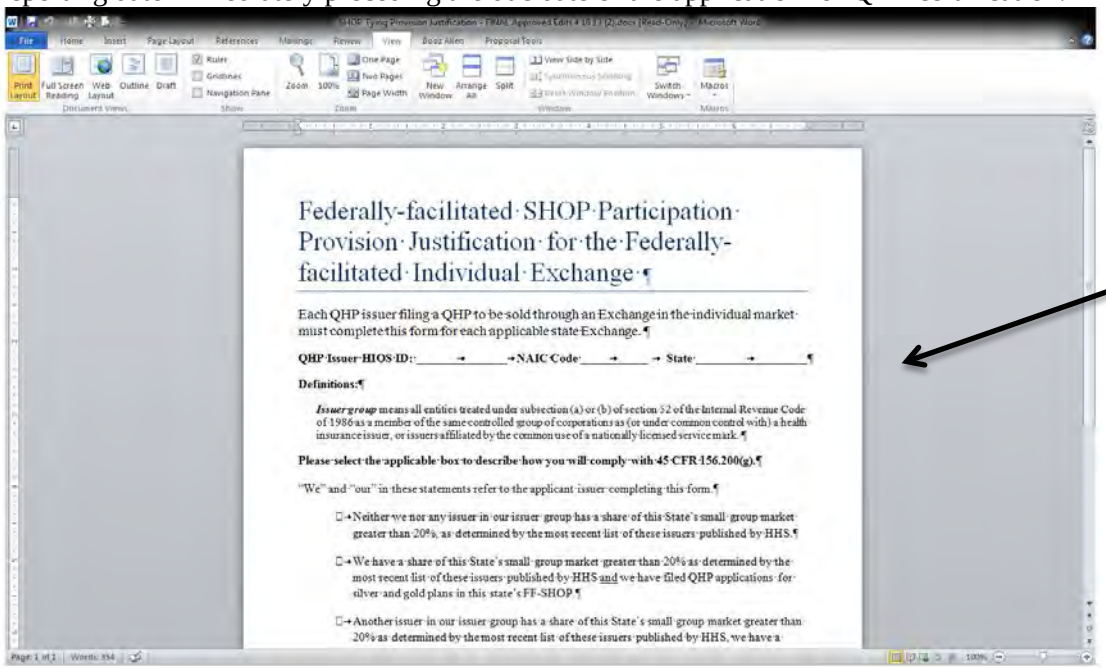
   § 156.200 QHP issuer participation standards.

   (g) *Certification standard specific to a Federally-facilitated Exchange.* A Federally-facilitated Exchange may certify a QHP in the individual market of a Federally-facilitated Exchange only if the QHP issuer meets one of the conditions below:

   (1) The QHP issuer also offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act;

   (2) The QHP issuer does not offer small group market products in that State, but another issuer in the same issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

   (3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under § 158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.



Federally-facilitated SHOP Participation Provision Justification for the Federally-facilitated Individual Exchange

Each QHP issuer filing a QHP to be sold through an Exchange in the individual market must complete this form for each applicable state Exchange.

QHP Issuer HIOS ID: _____ → NAIC Code: _____ → State: _____

Definitions:

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

Please select the applicable box to describe how you will comply with 45 CFR 156.200(g).

"We" and "our" in these statements refer to the applicant issuer completing this form.

☐ Neither we nor any issuer in our issuer group has a share of this State's small group market greater than 20%, as determined by the most recent list of these issuers published by HHS.

☐ We have a share of this State's small group market greater than 20% as determined by the most recent list of these issuers published by HHS and we have filed QHP applications for silver and gold plans in this state's FF-SHOP.

☐ Another issuer in our issuer group has a share of this State's small group market greater than 20% as determined by the most recent list of these issuers published by HHS, we have a

Provider SHOP Tying Justification

2. Read the *SHOP Tying* Validation step descriptions carefully as subsequent *SHOP Tying* validation steps are conditional based on previous *SHOP Tying* validation steps' **Met** or **Not Met** compliance.

	A	B	C	D	E	F	G	H
1				SHOP Tying Review Process Steps				
2						Validation Results		
3					HIOS Issuer ID:	18637	30942	33674
4	Review	Review step	Review description and procedure	Step description	Source			
5				SHOP Tying Validation 1				
6	1		Determine whether issuer is subject to the SHOP Tying Provision (45 CFR §156.200(g)).					
7	1	a		Check to see if the issuer is on the list of issuers subject to the provision (list provided by CMS). If issuer is on the list, mark as met and leave remaining steps blank. If issuer is not on the list, leave this step blank and go to step 2.		Met		
8				SHOP Tying Validation 2				
9	2		Confirm SHOP Tying Provision Justification is uploaded.					
10	2	a		Check the supporting documentation for a SHOP Tying Provision Justification from the issuer. If the justification is found mark as met and go to step 3. If the justification is not found, mark as not met and leave step 3 blank.	SHOP Tying Provision Justification (supporting documentation)		Met	Not Met
11				SHOP Tying Validation 2				
12	3		Review the SHOP Tying Justification document.					
	3	a		If the issuer selected the first box (indicating that neither the issuer nor any issuer in its issuer group is subject to the provision), determine whether issuer is compliant by verifying that it has one silver-level QHP and one gold-level QHP SHOP plan by reviewing Market Coverage and Level of Coverage on the Plans & Benefits Template. If Market Coverage is set to "SHOP (Small Group)" and Level of Coverage is set to "Silver" for at			

Tools Overview | Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Tying | EHB | ECI

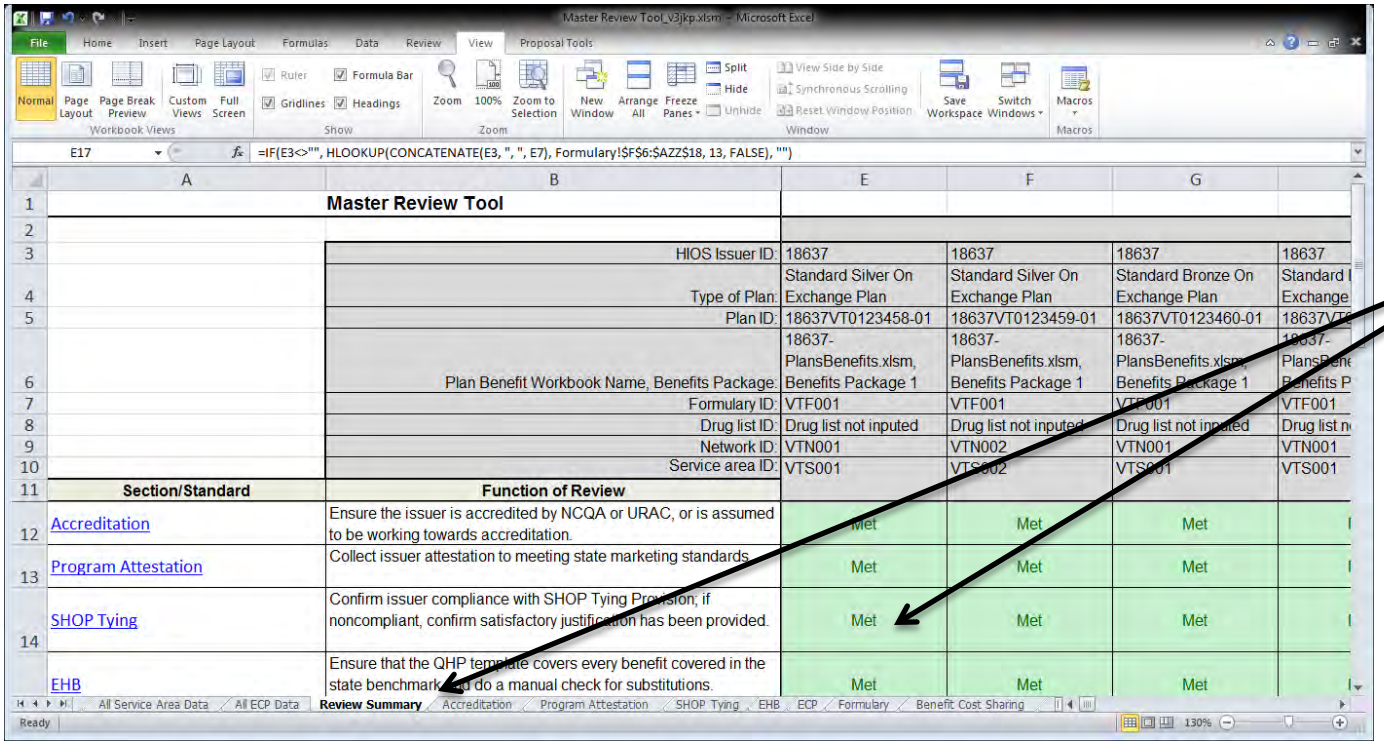
Read the *SHOP Tying* Validation step descriptions carefully as subsequent steps are conditional based on **Met** or **Not Met** compliance.

3. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *SHOP Tying* requirements.

	A	B	C	D	E	F	G	H
1				SHOP Tying Review Process Steps				
2						Validation Results		
3					HIOS Issuer ID:	18637	30942	33674
4	Review	Review step	Review description and procedure	Step description	Source			
18					Based on the previous validation steps, the program attestation review requirement for this issuer is:	Met	Met	Not Met

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

4. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Shop Tying* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.

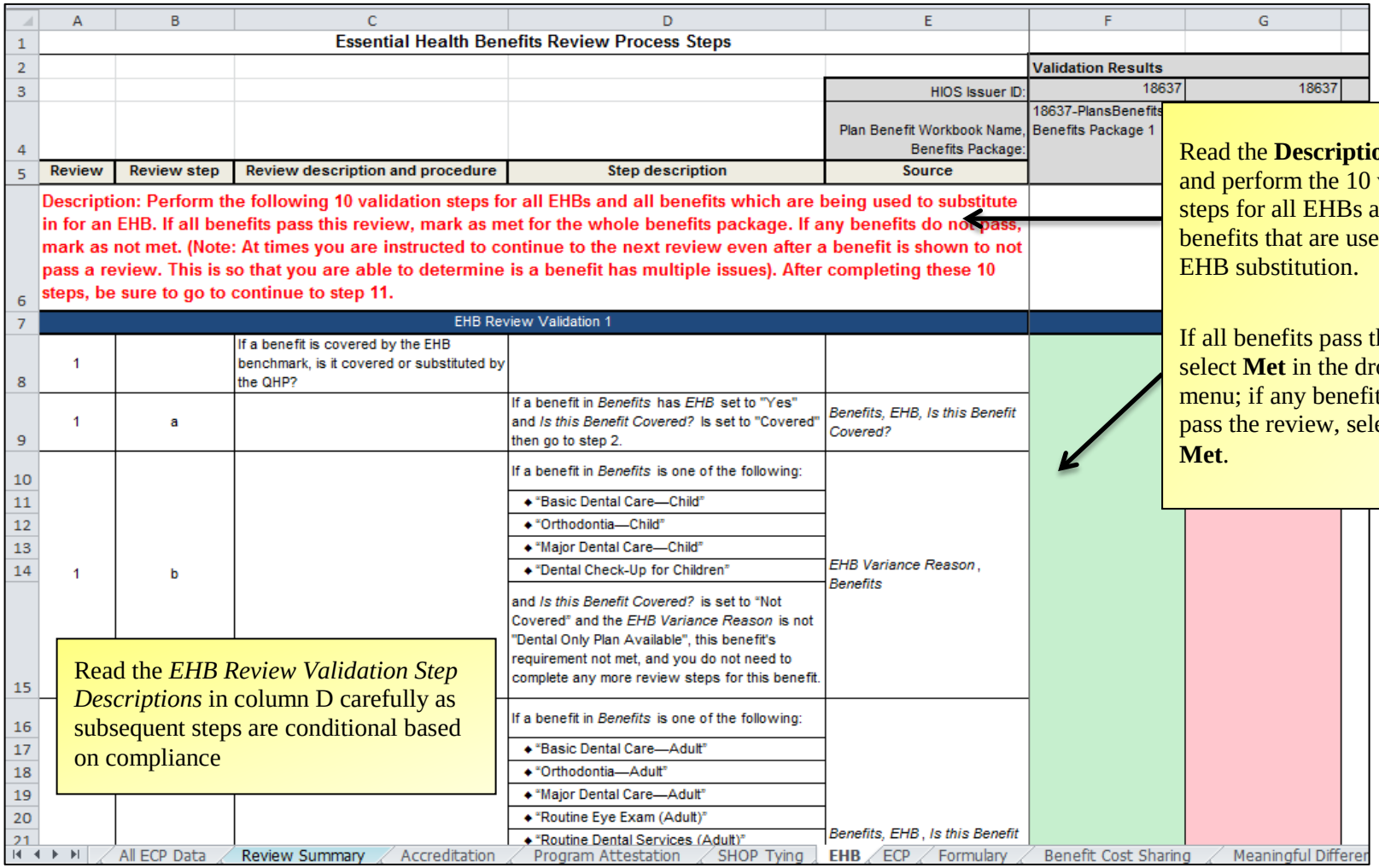


5. Save the Master Review Tool after you have completed the *Shop Tying* review.

V: ESSENTIAL HEALTH BENEFIT (EHB) REVIEW

The *Essential Health Benefit* (EHB) review confirms that the plan being reviewed complies with standards for the provision of EHB consistent with Federal rules. States may use form filings and/or the **Plans and Benefits Template to complete the *EHB* review.**

1. For Validations 1-12, read the **Description** in row 6 and perform the 10 validation steps for all EHBs and all benefits that are used as an EHB substitution. Read the *EHB Review Validation Step Descriptions* in column D carefully as subsequent steps are conditional based on compliance.



	A	B	C	D	E	F	G
1	Essential Health Benefits Review Process Steps						
2						Validation Results	
3					HIOS Issuer ID:	18637	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits Benefits Package 1	
5	Review	Review step	Review description and procedure	Step description	Source		
6	Description: Perform the following 10 validation steps for all EHBs and all benefits which are being used to substitute in for an EHB. If all benefits pass this review, mark as met for the whole benefits package. If any benefits do not pass, mark as not met. (Note: At times you are instructed to continue to the next review even after a benefit is shown to not pass a review. This is so that you are able to determine is a benefit has multiple issues). After completing these 10 steps, be sure to go to continue to step 11.						
7	EHB Review Validation 1						
8	1		If a benefit is covered by the EHB benchmark, is it covered or substituted by the QHP?				
9	1	a		If a benefit in *Benefits* has *EHB* set to "Yes" and *Is this Benefit Covered?* Is set to "Covered" then go to step 2.	*Benefits, EHB, Is this Benefit Covered?*		
10	1	b		If a benefit in *Benefits* is one of the following:	*EHB Variance Reason, Benefits*		
11				◆ "Basic Dental Care—Child"			
12				◆ "Orthodontia—Child"			
13				◆ "Major Dental Care—Child"			
14				◆ "Dental Check-Up for Children"			
15				and *Is this Benefit Covered?* is set to "Not Covered" and the *EHB Variance Reason* is not "Dental Only Plan Available", this benefit's requirement not met, and you do not need to complete any more review steps for this benefit.			
16				If a benefit in *Benefits* is one of the following:	*Benefits, EHB, Is this Benefit*		
17				◆ "Basic Dental Care—Adult"			
18				◆ "Orthodontia—Adult"			
19				◆ "Major Dental Care—Adult"			
20				◆ "Routine Eye Exam (Adult)"			
21				◆ "Routine Dental Services (Adult)"			

All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Differer

Read the **Description** in row 6 and perform the 10 validation steps for all EHBs and all benefits that are used as an EHB substitution.

If all benefits pass the review, select **Met** in the drop-down menu; if any benefits do not pass the review, select **Not Met**.

Read the *EHB Review Validation Step Descriptions* in column D carefully as subsequent steps are conditional based on compliance

	A	B	C	D	E	F	G
1	Essential Health Benefits Review Process Steps						
2						Validation Results	
3					HIOS Issuer ID:	18637	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1	18637-PlansBenefits, Benefits Package 2
5	Review	Review step	Review description and procedure	Step description	Source		
6	Description: Perform the following 10 validation steps for all EHBs and all benefits which are being used to substitute in for an EHB. If all benefits pass this review, mark as met for the whole benefits package. If any benefits do not pass, mark as not met. (Note: At times you are instructed to continue to the next review even after a benefit is shown to not pass a review. This is so that you are able to determine is a benefit has multiple issues). After completing these 10 steps, be sure to go to continue to step 11.						
7	EHB Review Validation 1						
8	1		If a benefit is covered by the EHB benchmark, is it covered or substituted by the QHP?				
9	1	a		If a benefit in *Benefits* has *EHB* set to "Yes" and *Is this Benefit Covered?* Is set to "Covered" then go to step 2.	*Benefits, EHB, Is this Benefit Covered?*		
10	1	b		If a benefit in *Benefits* is one of the following: ◆ "Basic Dental Care—Child" ◆ "Orthodontia—Child" ◆ "Major Dental Care—Child" ◆ "Dental Check-Up for Children" and *Is this Benefit Covered?* is set to "Not Covered" and the *EHB Variance Reason* is not "Dental Only Plan Available", this benefit's requirement not met, and you do not need to complete any more review steps for this benefit.	*EHB Variance Reason, Benefits*		
16				If a benefit in *Benefits* is one of the following: ◆ "Basic Dental Care—Adult" ◆ "Orthodontia—Adult" ◆ "Major Dental Care—Adult" ◆ "Routine Eye Exam (Adult)" ◆ "Routine Dental Services (Adult)"	*Benefits, EHB, Is this Benefit*		

All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Differenc

To complete *EHB Review Validation 1a-1k*, use the form filings or Plans and Benefits Templates data from *Benefits, EHB, Is this Benefit Covered?* and *EHB Variance Reason*.

	A	B	C	D	E	F	G	H	I	J	K	L
59	Benefit Information				General Information							
60	Benefits	EHB	State Mandate		Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Explanation (text field)	EHB Variance Reason
61	Primary Care Visit to Treat an Injury or Illness	Yes			Covered							
62	Specialist Visit	Yes			Covered							
63	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes			Covered							
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes		Covered							
65	Outpatient Surgery Physician/Surgical Services	Yes			Covered						Quantitative limit units	

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances

	A	B	C	D	E	F
1	**Essential Health Benefits Review Process Steps**					
2						**Validation Results**
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	**Review**	**Review step**	**Review description and procedure**	**Step description**	**Source**	
53	EHB Review Validation 2					
54	2		If a benefit in *Benefits* is covered by the EHB benchmark and *EHB Variance Reason* is not "Substituted," is *Limit Unit* acceptable?			
55	2	a		If a benefit in *Benefits* has *Limit Unit* equal to null, EHB benchmark has at least one *Limit Unit*, the *Explanation* for the benefit does not contain the *Limit Unit*, and there is nothing in the *EHB Variance Reason*, go to step 3; otherwise go to step 2b.	*Benefits, Limit Unit, Explanation, EHB Variance Reason*	

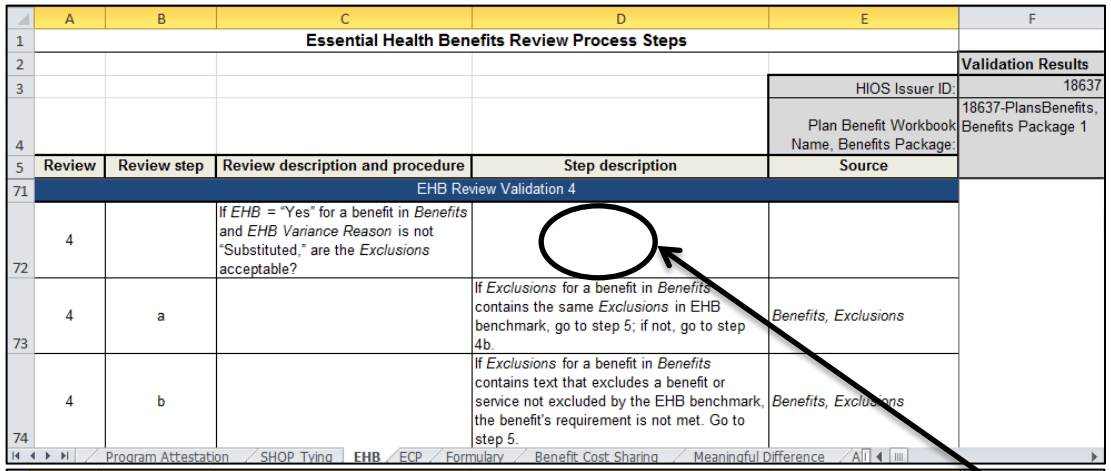
	A	B	C	D	E	F
1	**Essential Health Benefits Review Process Steps**					
2						**Validation Results**
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	**Review**	**Review step**	**Review description and procedure**	**Step description**	**Source**	
63	EHB Review Validation 3					
64	3		If *EHB* = "Yes" for a benefit in *Benefits*, *EHB Variance Reason* is not "Substituted," and the *Limit Unit* is the same as EHB benchmark, is *Limit Quantity* acceptable?			
65	3	a		For each benefit in *Benefits* that has *EHB* equal to "Yes," calculate a quantitative limit threshold (using *Limit Quantity*) of the EHB benchmark (proposed threshold = 75% of EHB benchmark's limit quantity).	*Benefits, Limit Quantity*	

Program Attestation | SHOP Tying | **EHB** | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference

	A	B	C	D	E	F	G	H	I	J	K	L
59	***Benefit Information***				***General Information***							
60	**Benefits**		**EHB**	**State Mandate**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Explanation (text field)**	**EHB Variance Reason**
61	Primary Care Visit to Treat an Injury or Illness		Yes		Covered							
62	Specialist Visit		Yes		Covered							
63	Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes		Covered							
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	Yes	Covered							
65	Outpatient Surgery Physician/Surgical Services		Yes		Covered						Quantitative limit units	

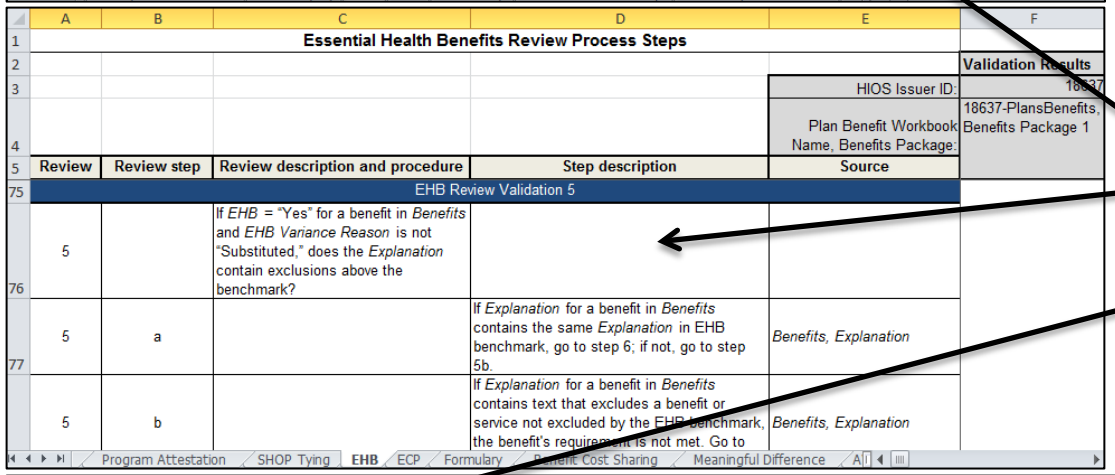
Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances

To complete *EHB Review Validation 2a-2h* and *3a-3f*, use the form filings or Plans and Benefits Templates data from the *Benefits*, *EHB*, *Limit Quantity*, *Limit Unit*, *Explanation*, and *EHB Variance Reason*.



	A	B	C	D	E	F
1			Essential Health Benefits Review Process Steps			
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
71			EHB Review Validation 4			
72	4		If *EHB* = "Yes" for a benefit in *Benefits* and *EHB Variance Reason* is not "Substituted," are the *Exclusions* acceptable?			
73	4	a		If *Exclusions* for a benefit in *Benefits* contains the same *Exclusions* in EHB benchmark, go to step 5; if not, go to step 4b.	*Benefits, Exclusions*	
74	4	b		If *Exclusions* for a benefit in *Benefits* contains text that excludes a benefit or service not excluded by the EHB benchmark, the benefit's requirement is not met. Go to step 5.	*Benefits, Exclusions*	

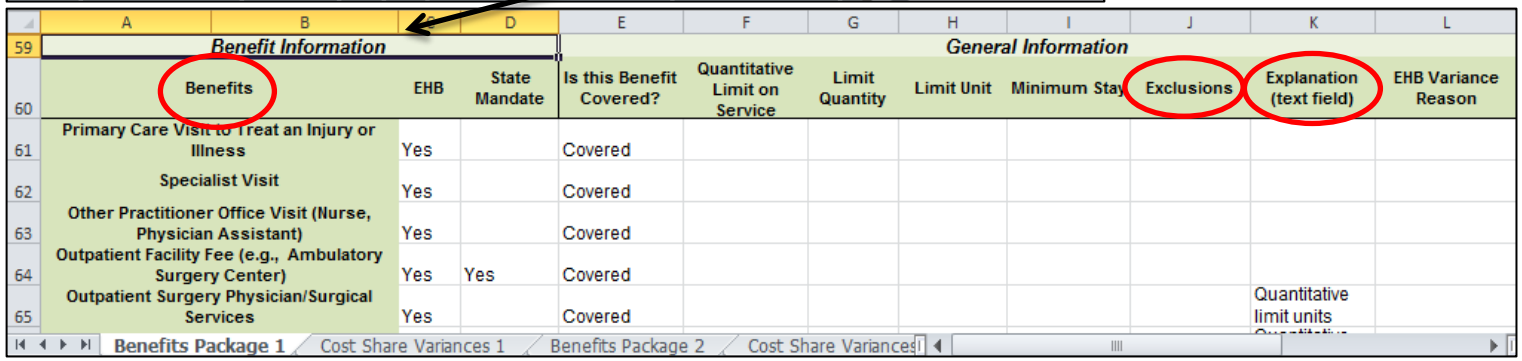
Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference



	A	B	C	D	E	F
1			Essential Health Benefits Review Process Steps			
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
75			EHB Review Validation 5			
76	5		If *EHB* = "Yes" for a benefit in *Benefits* and *EHB Variance Reason* is not "Substituted," does the *Explanation* contain exclusions above the benchmark?			
77	5	a		If *Explanation* for a benefit in *Benefits* contains the same *Explanation* in EHB benchmark, go to step 6; if not, go to step 5b.	*Benefits, Explanation*	
	5	b		If *Explanation* for a benefit in *Benefits* contains text that excludes a benefit or service not excluded by the EHB benchmark, the benefit's requirement is not met. Go to	*Benefits, Explanation*	

Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference

To complete *EHB Review Validation 4a-4b* and *5a-5b*, use the form filings or Plans and Benefits Templates data from the *Benefits*, *Exclusions*, and *Explanation*.



	A	B	D	E	F	G	H	I	J	K	L
59		*Benefit Information*		*General Information*							
60		Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Explanation (text field)	EHB Variance Reason
61		Primary Care Visit to Treat an Injury or Illness	Yes		Covered							
62		Specialist Visit	Yes		Covered							
63		Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered							
64		Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Covered							
65		Outpatient Surgery Physician/Surgical Services	Yes		Covered						Quantitative limit units	

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances

	A	B	C	D	E	F
1	Essential Health Benefits Review Process Steps					
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
79	EHB Review Validation 6					
80	6		If *EHB* = "Yes" for a benefit in *Benefits* and *EHB Variance Reason* is not "Substituted," or *EHB Variance Reason* is "Additional EHB Benefit," ensure that no discriminatory age limitations on services exist.			
81	6	a		If *Explanation* for a benefit in *Benefits* contains text referencing an age limitation on a service and the benefit and age limitations are not on the list of age limitations found in the state's EHB benchmark, this benefit's requirement is not met. Go to step 6b.	*Benefits, Explanation,* list of age limitations found in the state's EHB benchmark	

Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference

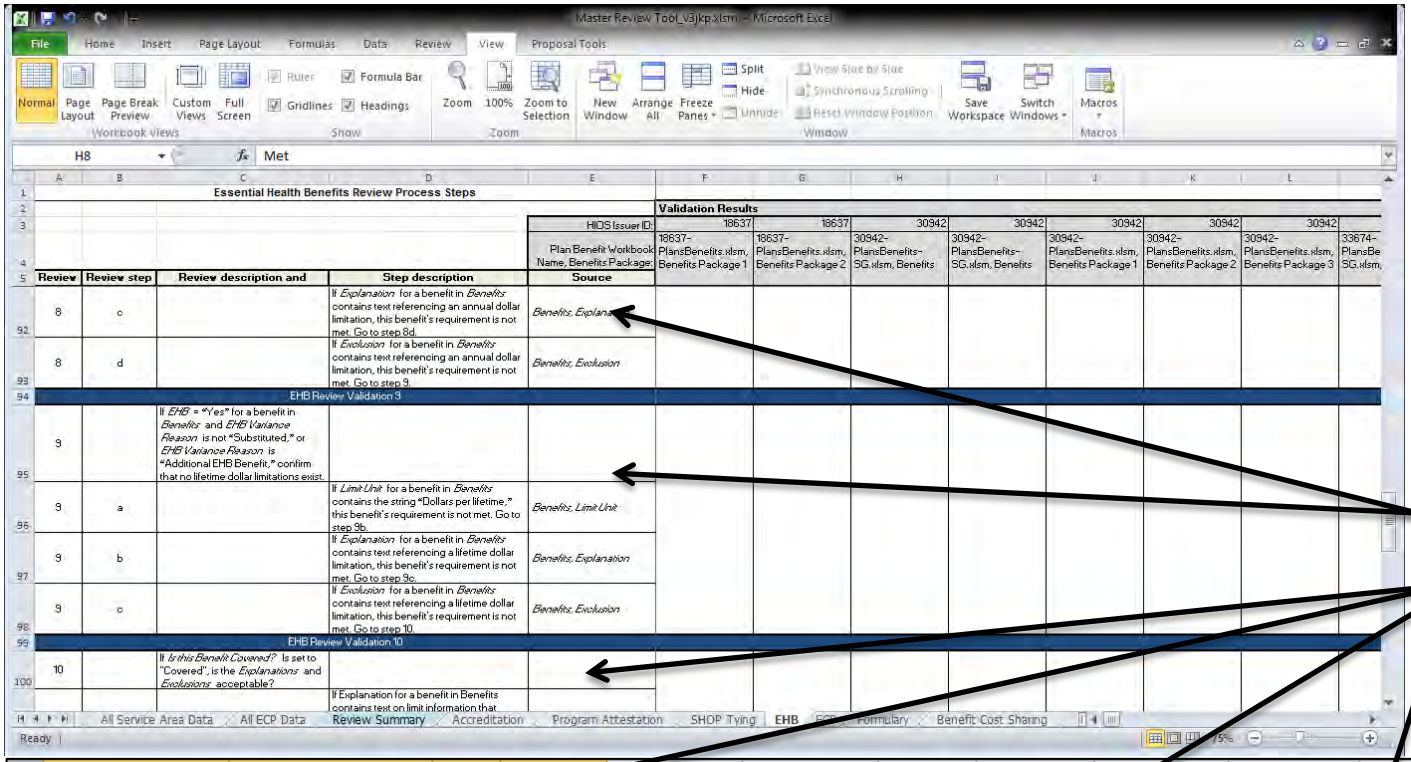
	A	B	C	D	E	F
1	Essential Health Benefits Review Process Steps					
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
83	EHB Review Validation 7					
84	7		If *EHB* = "Yes" for a benefit in *Benefits* and *EHB Variance Reason* is not "Substituted," or *EHB Variance Reason* is "Additional EHB Benefit," ensure that no discriminatory condition limitations on services exist.			
	7	a		If *Explanation* for a benefit in *Benefits* contains text referencing a condition limitation on a service and the benefit and condition limitations are not on the list of condition limitations found in the state's EHB benchmark, this benefit's requirement is not	*Benefits, Explanation,* list of condition limitations found in the state's EHB benchmark	

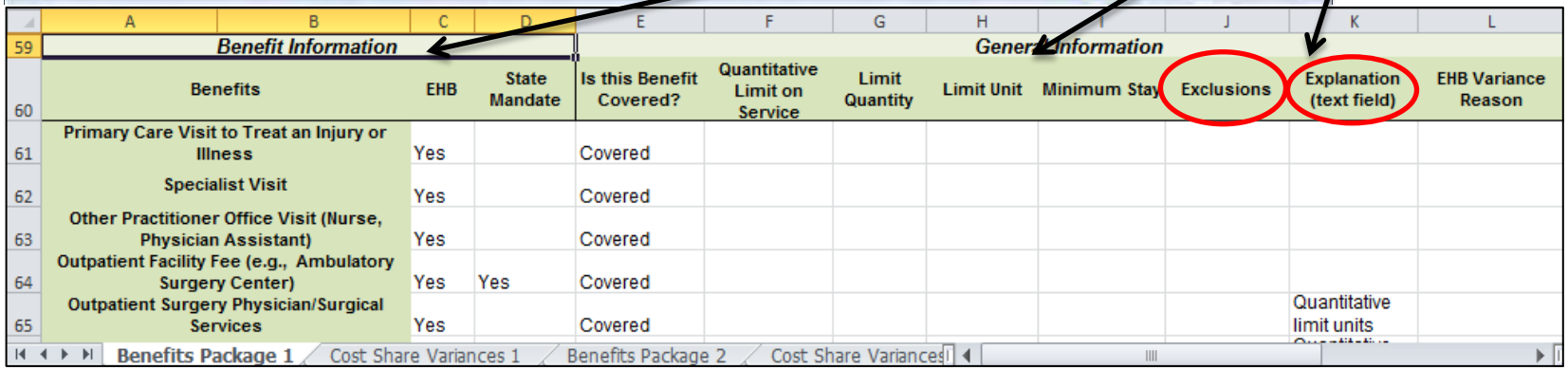
Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference

To complete *EHB Review Validation 6a-6b* and *7a-7b*, use the form filings or Plans and Benefits Templates data from the *Benefits*, *Exclusions*, and *Explanation.*

	A	B	C	D	E	F	G	H	I	J	K	L
59	Benefit Information				General Information							
60	Benefits	EHB	State Mandate		Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Explanation (text field)	EHB Variance Reason
61	Primary Care Visit to Treat an Injury or Illness	Yes			Covered							
62	Specialist Visit	Yes			Covered							
63	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes			Covered							
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes		Covered							
65	Outpatient Surgery Physician/Surgical Services	Yes			Covered						Quantitative limit units	

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances





To complete *EHB Review Validation 8a-8d, 9a-9c* and *10a-10b*, use the form filings or Plans and Benefits Templates data from the *Benefits*, *Limit Unit*, *Exclusions*, and *Explanation.*

	A	B	C	D	E	F
1	Essential Health Benefits Review Process Steps					
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
109	EHB Review Validation 11					
110	11		Confirm that mental health parity exists.			
111	11	a		If a benefit in *Benefits* is one of the following:	*Benefits, Limit Quantity, Limit Unit*	
112				◆ "Mental/Behavioral Health Outpatient Services"		
113				◆ "Mental/Behavioral Health Inpatient Services"		
114				◆ "Substance Use Disorder Outpatient Services"		
115				◆ "Substance Use Disorder Inpatient Services"		
116				and is not in parity to a *Limit Quantity* respective to medical/surgical health benefits mark as not met.		
117	11	b		If a benefit in *Benefits* is one of the following:	*Benefits, Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network, Coinsurance—In Network (Tier 1), Coinsurance—In Network (Tier 2), Coinsurance—Out of Network*	
118				◆ "Mental/Behavioral Health Outpatient Services"		
119				◆ "Mental/Behavioral Health Inpatient Services"		
120				◆ "Substance Use Disorder Outpatient Services"		
121				◆ "Substance Use Disorder Inpatient Services"		
122				and is not in parity to cost sharing respective to medical/surgical health benefits mark as not met.		

Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation

To complete *EHB Review Validation 11a*, use the form filings or Plans and Benefits Templates data from the *Benefits*, *Limit Quantity*, and *Limit Unit* for Copay and Coinsurance information.

	A	B	C	D	E	F	G	H
59	Benefit Information							Ger
60	Benefits		EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit
61	Primary Care Visit to Treat an Injury or Illness		Yes		Covered			
62	Specialist Visit		Yes		Covered			
63	Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes		Covered			
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	Yes	Covered			

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Va

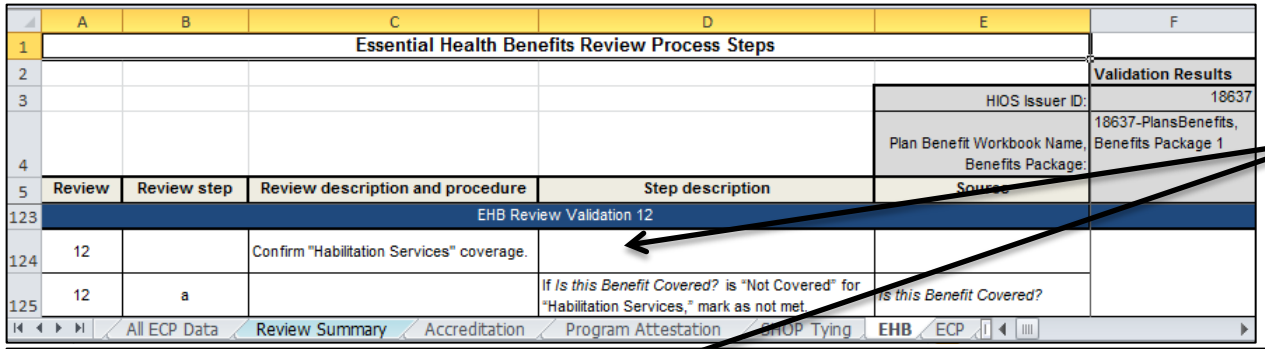
	A	B	C	D	E	F
1	Essential Health Benefits Review Process Steps					
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
109	EHB Review Validation 11					
110	11		Confirm that mental health parity exists.			
111	11	a		If a benefit in *Benefits* is one of the following:	*Benefits, Limit Quantity , Limit Unit*	
112				◆ "Mental/Behavioral Health Outpatient Services"		
113				◆ "Mental/Behavioral Health Inpatient Services"		
114				◆ "Substance Use Disorder Outpatient Services"		
115				◆ "Substance Use Disorder Inpatient Services"		
116				and is not in parity to a *Limit Quantity* respective to medical/surgical health benefits mark as not met.		
117	11	b		If a benefit in *Benefits* is one of the following:	*Benefits, Copay—In Network (Tier 1) , Copay—In Network (Tier 2) , Copay—Out of Network , Coinsurance—In Network (Tier 1) , Coinsurance—In Network (Tier 2) , Coinsurance—Out of Network*	
118				◆ "Mental/Behavioral Health Outpatient Services"		
119				◆ "Mental/Behavioral Health Inpatient Services"		
120				◆ "Substance Use Disorder Outpatient Services"		
121				◆ "Substance Use Disorder Inpatient Services"		
122				and is not in parity to cost sharing respective to medical/surgical health benefits mark as not met.		

Instructions | All Plan Data | All Service Area Data | All ECP Data | Review Summary | Accreditation

	C	D	IF	IG	IH	II	IJ	IK	IL	IM	IN	IO	IP	IQ
			Mental/Behavioral Health Outpatient Services						Mental/Behavioral Health Inpatient Services					
	Cost Sh		Copay			Coinsurance			Copay			Coinsurance		
	keting e*	Level of Coverage* (Metal Level)	CSR Variation Type*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
		Bronze	Standard Bronze Off Exchan	$100 Copay before deductible	$64	$69 Copay after deductible	11%	29%	24%	$20 Copay after deductible	$81 Copay before deductible	No Charge	60%	46%	12%
		Bronze	Standard Bronze On Exchan	$100 Copay before deductible	$64	$69 Copay after deductible	11%	29%	24%	$20 Copay after deductible	$81 Copay before deductible	No Charge	60%	46%	12%

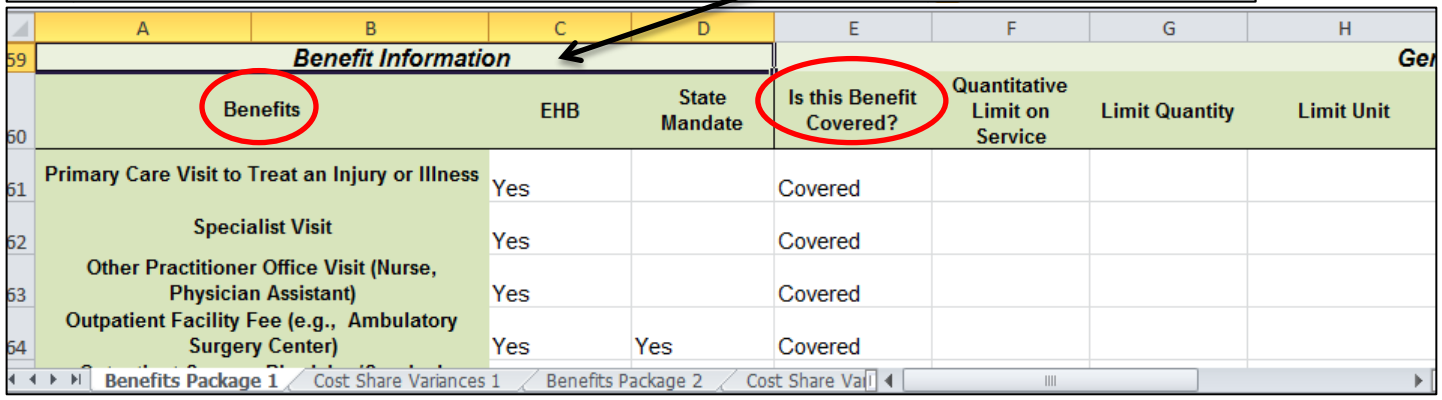
Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances 2 | Benefits Package 3 | C

To complete *EHB Review Validation 11b*, use the form filings or Plans and Benefits Templates *Cost Share Variances* tab data for Copay and Coinsurance information.



	A	B	C	D	E	F
1	Essential Health Benefits Review Process Steps					
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1
5	Review	Review step	Review description and procedure	Step description	Source	
123	EHB Review Validation 12					
124	12		Confirm "Habilitation Services" coverage.			
125	12	a		If *Is this Benefit Covered?* is "Not Covered" for "Habilitation Services," mark as not met.	*Is this Benefit Covered?*	

All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Tying | EHB | ECP

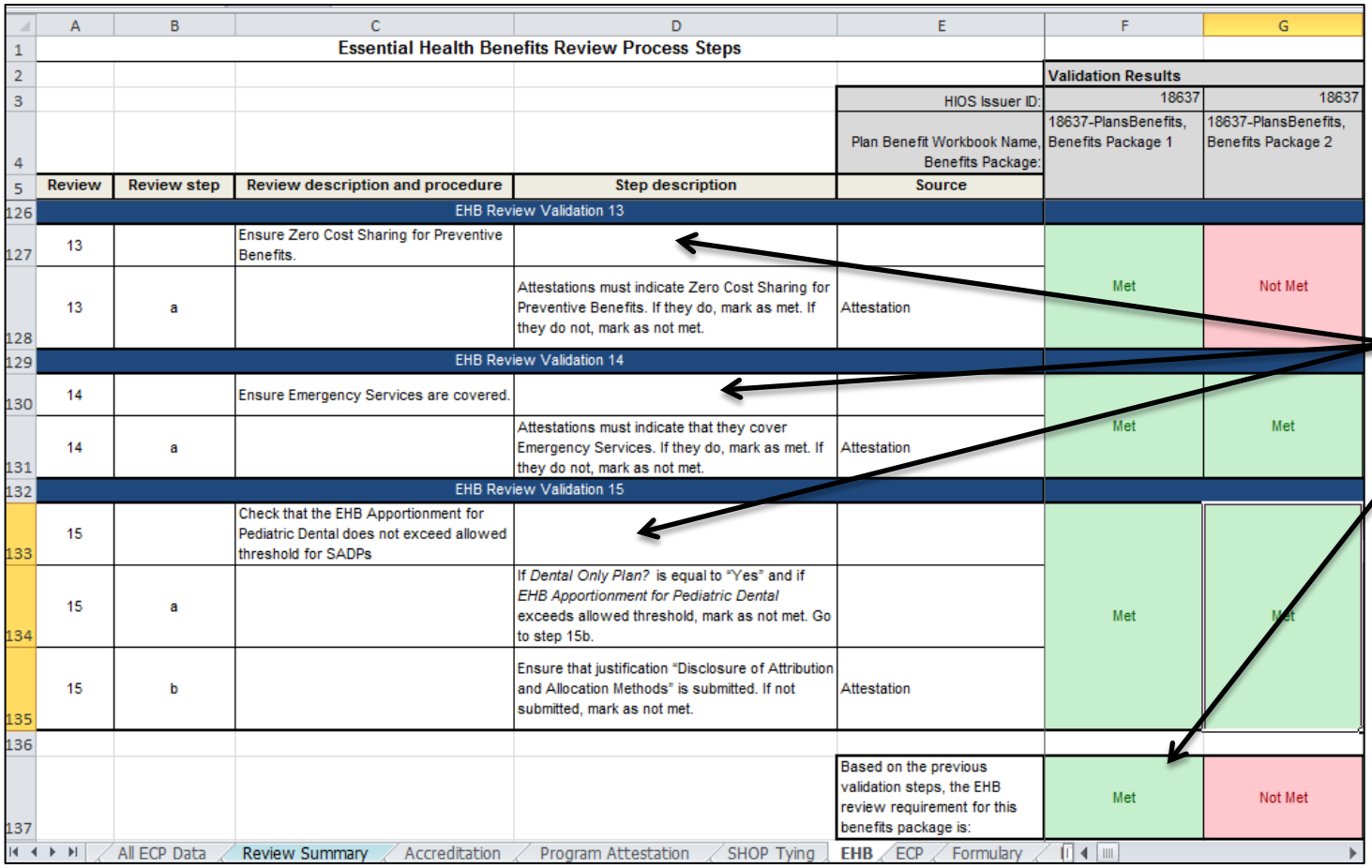


	A	B	C	D	E	F	G	H
59	*Benefit Information*							*Ge*
60	Benefits		EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit
61	Primary Care Visit to Treat an Injury or Illness		Yes		Covered			
62	Specialist Visit		Yes		Covered			
63	Other Practitioner Office Visit (Nurse, Physician Assistant)		Yes		Covered			
64	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Yes	Yes	Covered			

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Va

To complete *EHB Review Validation 12*, use the form filings or Plans and Benefits Templates data for *Benefits* and *Is this Benefit covered?*

2. To complete *EHB Review Validations 13-15*, use the General Issuer Attestation.
3. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *EHB* requirements.



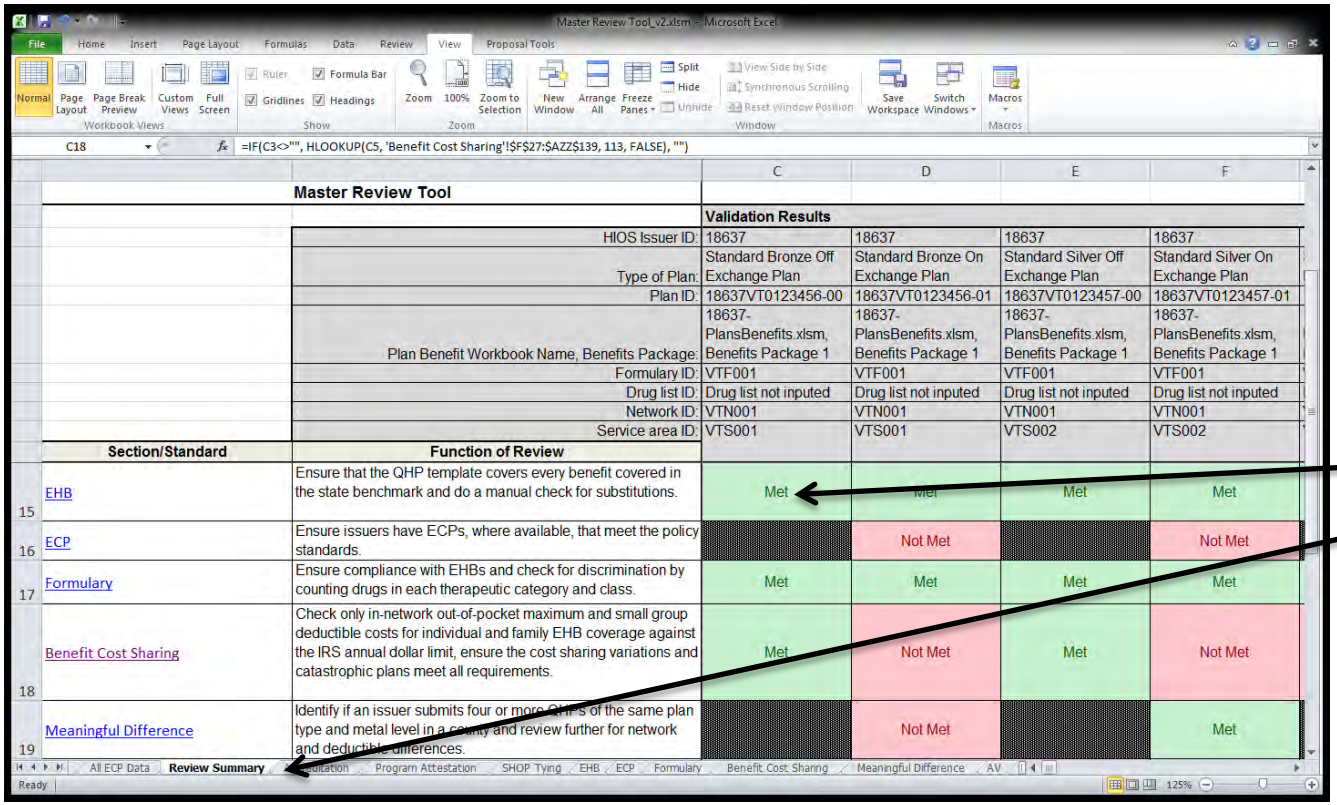
	A	B	C	D	E	F	G
1	Essential Health Benefits Review Process Steps						
2						Validation Results	
3					HIOS Issuer ID:	18637	18637
4					Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits, Benefits Package 1	18637-PlansBenefits, Benefits Package 2
5	Review	Review step	Review description and procedure	Step description	Source		
126	EHB Review Validation 13						
127	13		Ensure Zero Cost Sharing for Preventive Benefits.				
128	13	a		Attestations must indicate Zero Cost Sharing for Preventive Benefits. If they do, mark as met. If they do not, mark as not met.	Attestation	Met	Not Met
129	EHB Review Validation 14						
130	14		Ensure Emergency Services are covered.				
131	14	a		Attestations must indicate that they cover Emergency Services. If they do, mark as met. If they do not, mark as not met.	Attestation	Met	Met
132	EHB Review Validation 15						
133	15		Check that the EHB Apportionment for Pediatric Dental does not exceed allowed threshold for SADPs				
134	15	a		If *Dental Only Plan?* is equal to "Yes" and if *EHB Apportionment for Pediatric Dental* exceeds allowed threshold, mark as not met. Go to step 15b.		Met	Met
135	15	b		Ensure that justification "Disclosure of Attribution and Allocation Methods" is submitted. If not submitted, mark as not met.	Attestation		
136							
137					Based on the previous validation steps, the EHB review requirement for this benefits package is:	Met	Not Met

All ECP Data | Review Summary | Accreditation | Program Attestation | SHOP Tying | EHB | ECP | Formulary

To complete *EHB Review Validations 13-15*, use the General Issuer Attestation.

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

3. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *EHB* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool

		Validation Results			
	HIOS Issuer ID:	18637	18637	18637	18637
	Type of Plan:	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
	Plan ID:	18637VT0123456-00	18637VT0123456-01	18637VT0123457-00	18637VT0123457-01
	Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1
	Formulary ID:	VTF001	VTF001	VTF001	VTF001
	Drug list ID:	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
	Network ID:	VTN001	VTN001	VTN001	VTN001
	Service area ID:	VTS001	VTS001	VTS002	VTS002
	Section/Standard	Function of Review			
15	EHB	Ensure that the QHP template covers every benefit covered in the state benchmark and do a manual check for substitutions.	Met	Met	Met	Met
16	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.		Not Met		Not Met
17	Formulary	Ensure compliance with EHBs and check for discrimination by counting drugs in each therapeutic category and class.	Met	Met	Met	Met
18	Benefit Cost Sharing	Check only in-network out-of-pocket maximum and small group deductible costs for individual and family EHB coverage against the IRS annual dollar limit, ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Not Met	Met	Not Met
19	Meaningful Difference	Identify if an issuer submits four or more QHP's of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met

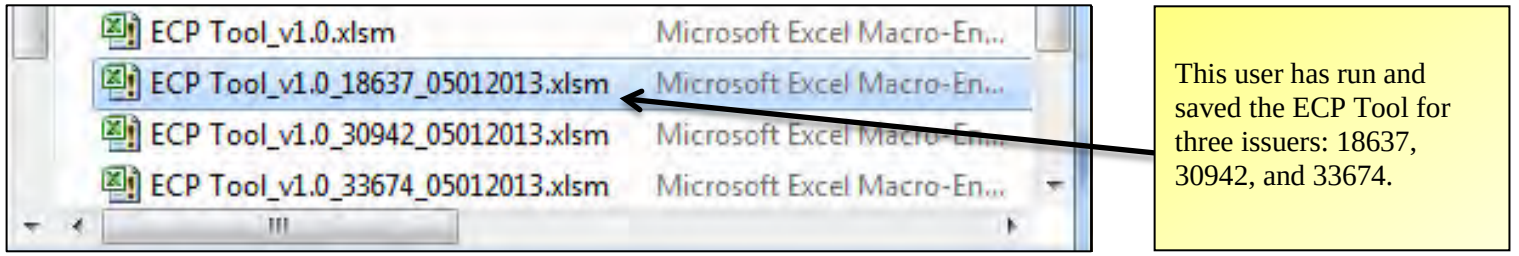
Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

4. Save the Master Review Tool after you have completed the *EHB* review.

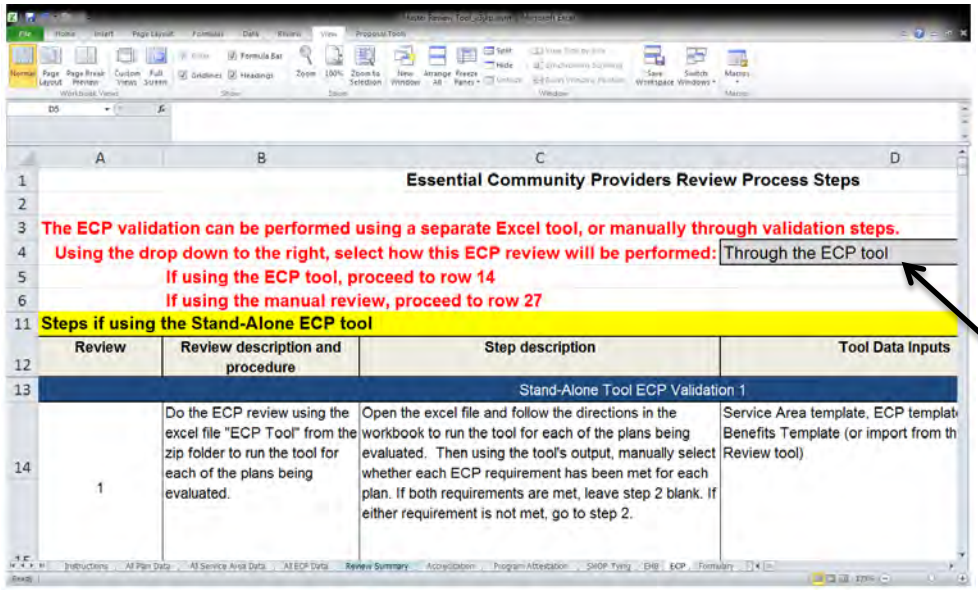
VI: ESSENTIAL COMMUNITY PROVIDER (ECP) REVIEW

The ECP review process in the Master Review Tool ensures issuers have ECPs, where available, that meet the FFM minimum expectation percentage (recommended to be at least 10 percent of available ECPs) and the safe harbor standard percentage (recommended to be at least 20 percent of available ECPs).

1. Open the Qualified Health Plan Application State Review Tools folder and run the ECP Tool for all the issuers' plans you wish to evaluate. You must run the ECP Tool only one issuer at a time, so be sure to save each completed ECP Tool with a unique filename, e.g., by issuer ID. For more information on running the ECP Tool, see section II. ECP Tool in the *QHP Application State Review Tools User Guide: Loading the Data*



3. If you decide to use the ECP stand-alone tool, review the validation steps in the Master Review Tool *ECP* tab to better understand the logic behind the ECP Tool or to see where you can submit justifications.



Essential Community Providers Review Process Steps

The ECP validation can be performed using a separate Excel tool, or manually through validation steps.

Using the drop down to the right, select how this ECP review will be performed: Through the ECP tool

If using the ECP tool, proceed to row 14

If using the manual review, proceed to row 27

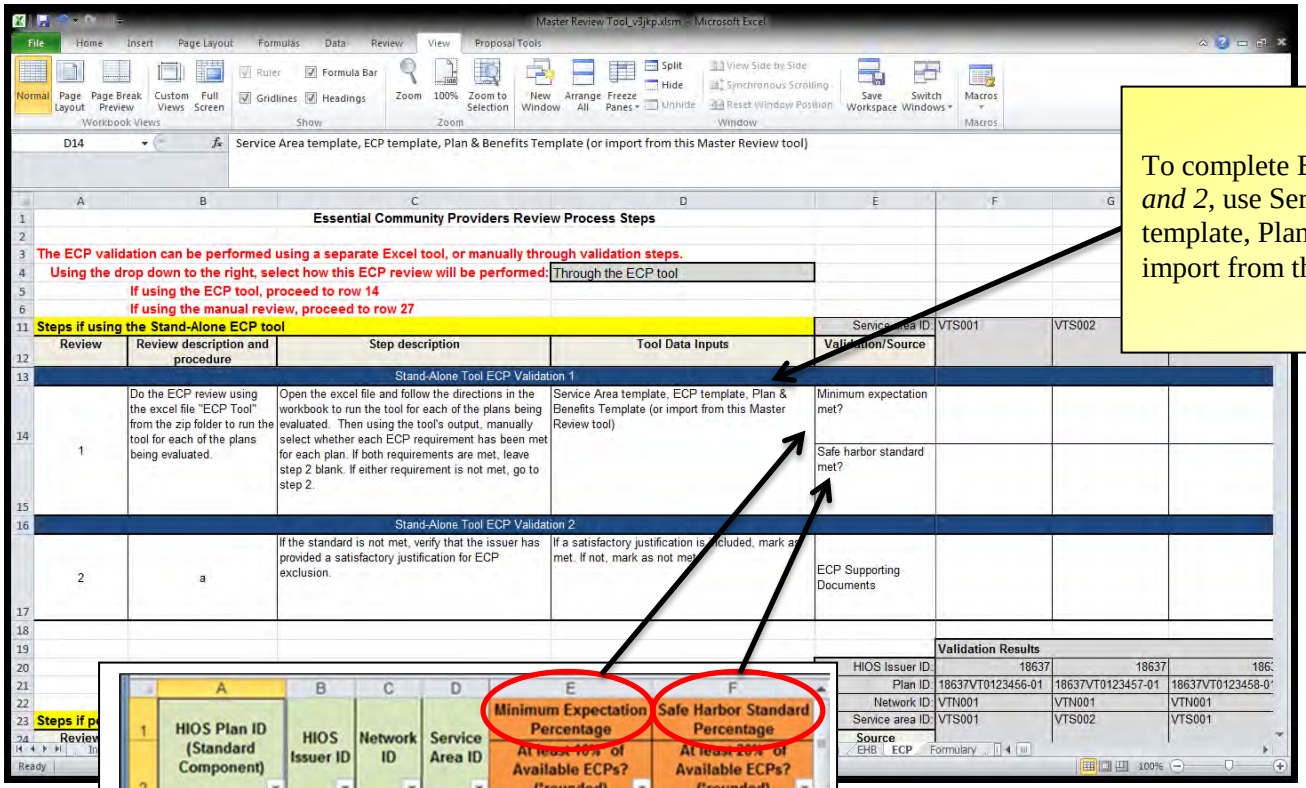
Steps if using the Stand-Alone ECP tool

Review	Review description and procedure	Step description	Tool Data Inputs
Stand-Alone Tool ECP Validation 1			
1	Do the ECP review using the excel file "ECP Tool" from the zip folder to run the tool for each of the plans being evaluated.	Open the excel file and follow the directions in the workbook to run the tool for each of the plans being evaluated. Then using the tool's output, manually select whether each ECP requirement has been met for each plan. If both requirements are met, leave step 2 blank. If either requirement is not met, go to step 2.	Service Area template, ECP templat Benefits Template (or import from th Review tool)

Open the Master Review Tool *ECP* tab to see the ECP review description.

Use the *drop-down menu* in cell D4 to select how you will perform the ECP review: *Manually* or *Through ECP Tool*.

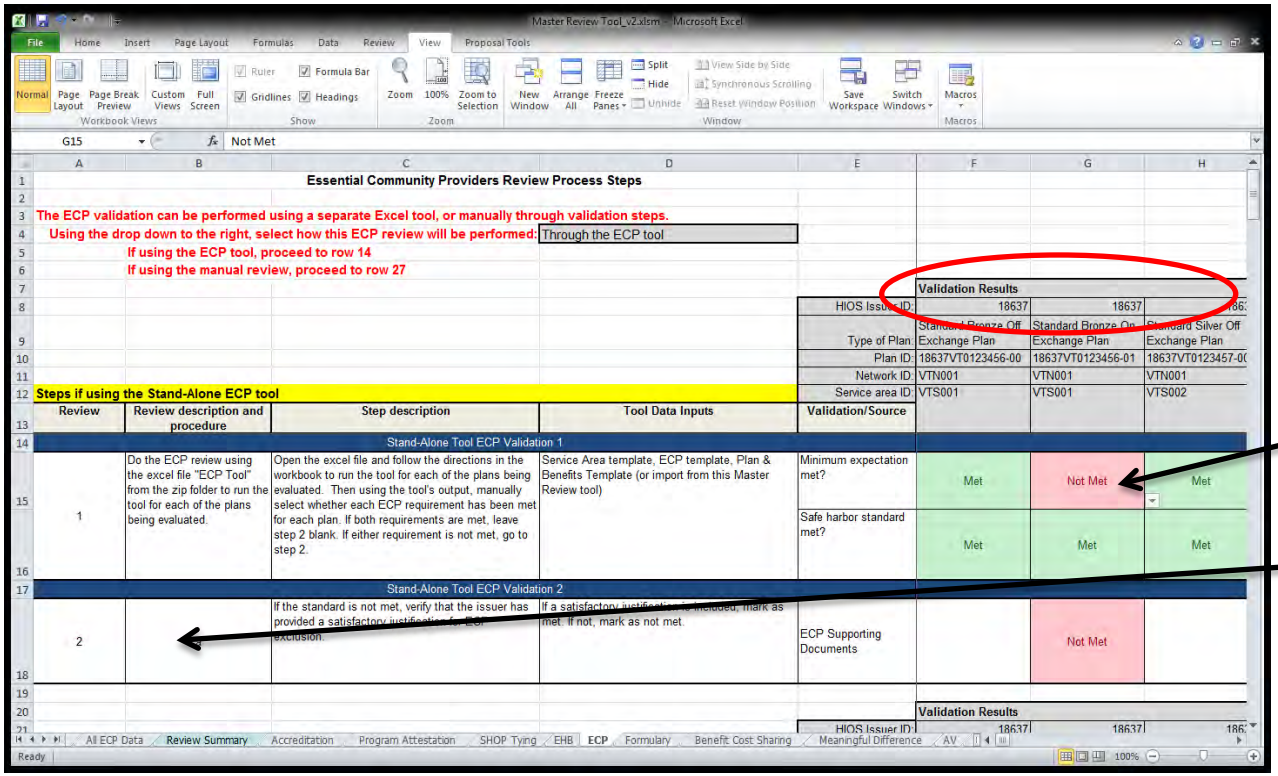
4. Open the ECP Tool *Output* tab to see the issuer's plans you wish to review.



To complete ECP Review *Validations 1 and 2*, use Service Area template, ECP template, Plans and Benefits Template (or import from this Master Review tool).

Open the completed ECP Tool *Output* tab to see the issuer's plans you to wish to review.

5. Using the data in the ECP Tool *Output* tab, go to the Master Review Tool *ECP* tab and use the drop-down menus in the *Validation Results* columns to indicate if an issuer's plan has met the minimum expectation percentage and the safe harbor standard percentage.

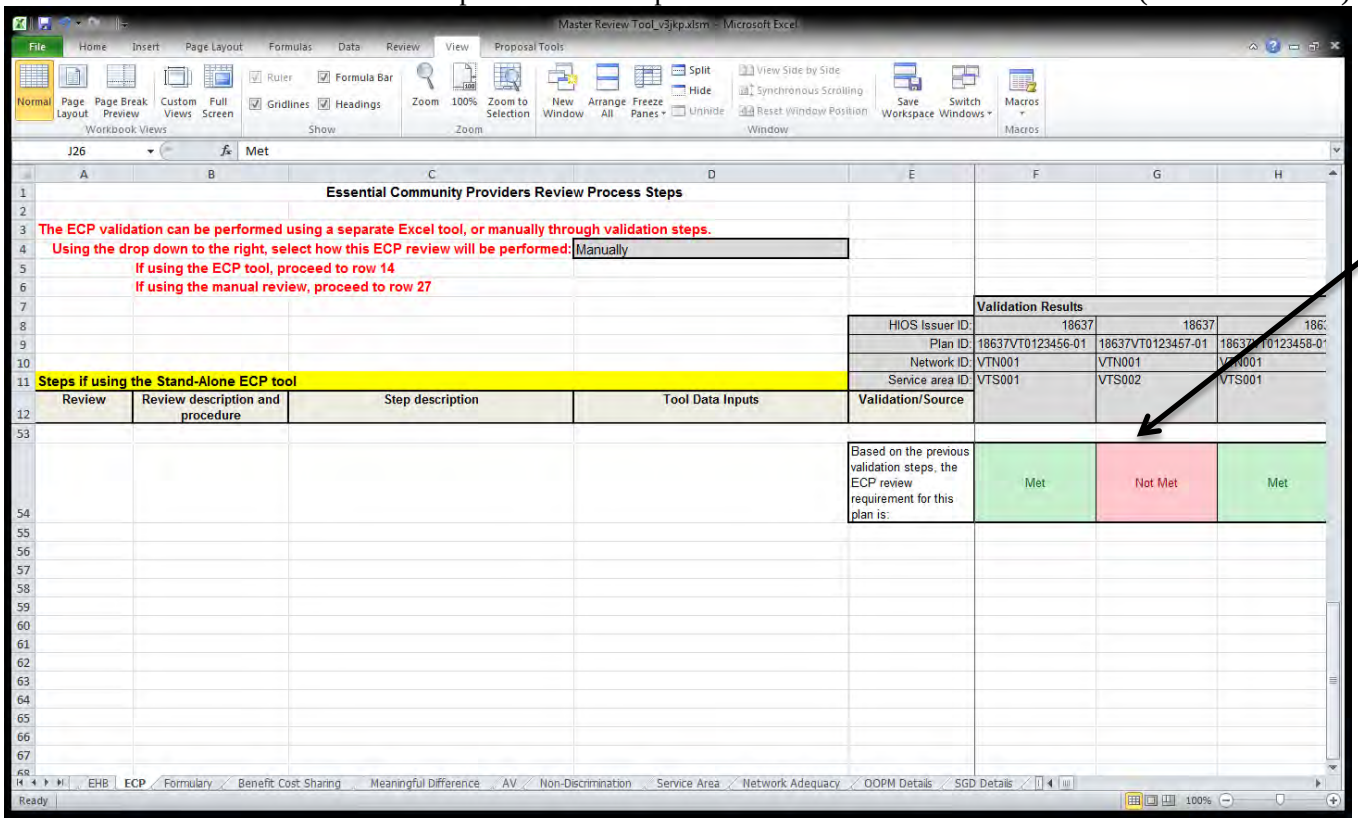


Use the *drop-down menus* to indicate **Met** or **Not Met** for each issuer's plan.

If the two ECP standards are **Met**, skip step 2.

If either of the ECP standards is **Not Met**, proceed to step 2, and follow the step description in cell C17 for justification.

5. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *ECP* requirements.



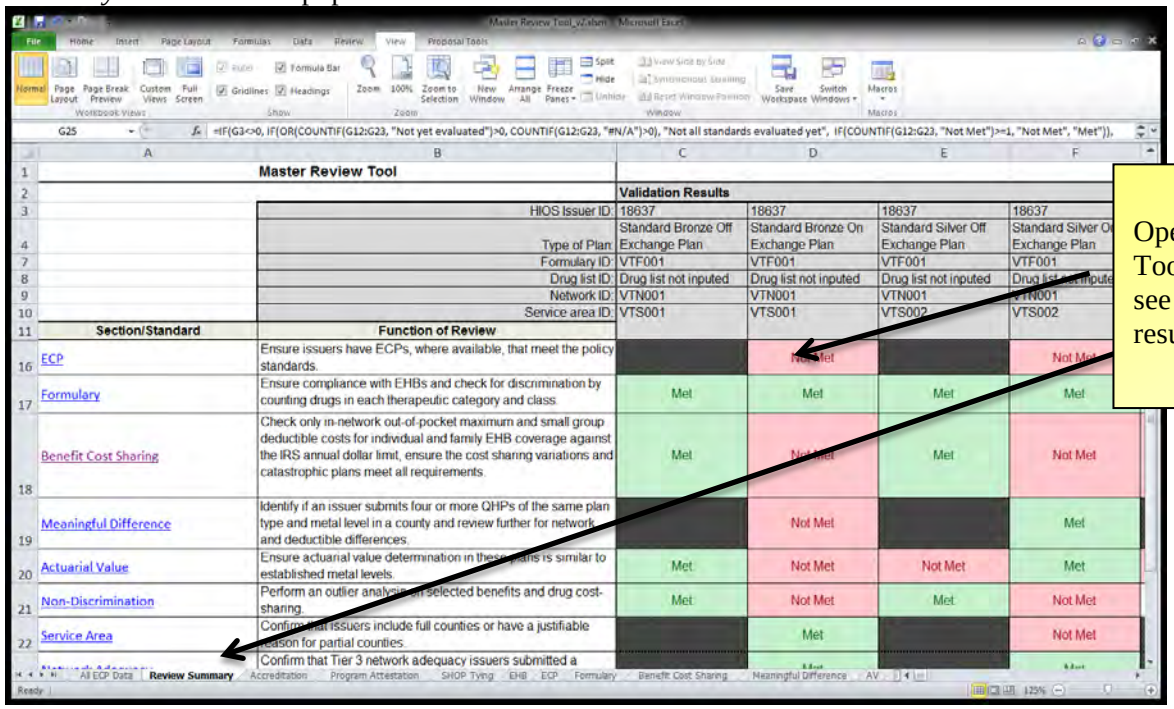
Essential Community Providers Review Process Steps

The ECP validation can be performed using a separate Excel tool, or manually through validation steps.
Using the drop down to the right, select how this ECP review will be performed: Manually
If using the ECP tool, proceed to row 14
If using the manual review, proceed to row 27

				Validation Results		
			HIOS Issuer ID:	18637	18637	186
			Plan ID:	18637VT0123456-01	18637VT0123457-01	18637VT0123458-0
			Network ID:	VTN001	VTN001	VTN001
Steps if using the Stand-Alone ECP tool			Service area ID:	VTS001	VTS002	VTS001
Review	Review description and procedure	Step description	Validation/Source			
			Based on the previous validation steps, the ECP review requirement for this plan is:	Met	Not Met	Met

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

6. Once you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *ECP* tab, open the Master Review Tool *Review Summary* to see the auto-populated results.



Master Review Tool

		Validation Results			
	HIOS Issuer ID:	18637	18637	18637	18637
	Type of Plan:	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
	Formulary ID:	VTF001	VTF001	VTF001	VTF001
	Drug list ID:	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
	Network ID:	VTN001	VTN001	VTN001	VTN001
	Service area ID:	VTS001	VTS001	VTS002	VTS002
Section/Standard	Function of Review				
ECP	Ensure issuers have ECPs, where available, that meet the policy standards.		Not Met		Not Met
Formulary	Ensure compliance with EHBs and check for discrimination by counting drugs in each therapeutic category and class.	Met	Met	Met	Met
Benefit Cost Sharing	Check only in-network out-of-pocket maximum and small group deductible costs for individual and family EHB coverage against the IRS annual dollar limit, ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Not Met	Met	Not Met
Meaningful Difference	Identify if an issuer submits four or more QHPs of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met
Actuarial Value	Ensure actuarial value determination in these plans is similar to established metal levels.	Met	Not Met	Not Met	Met
Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
	Confirm that Tier 3 network adequacy issuers submitted a				

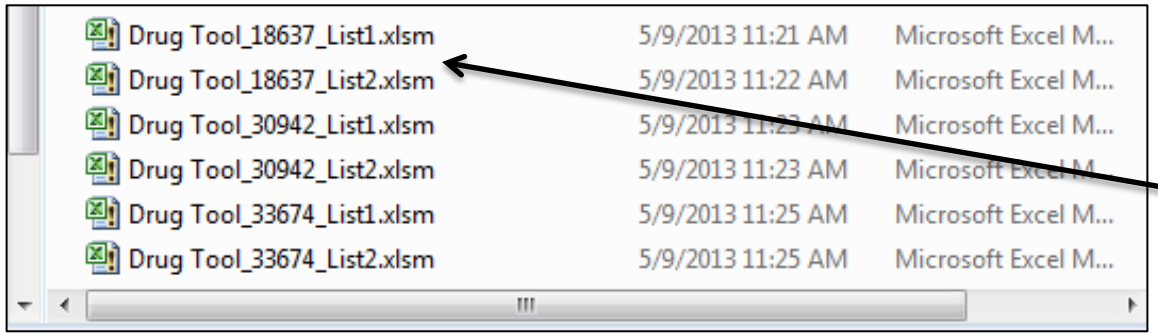
Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

7. Save the Master Review Tool after you have completed the ECP review.

VII: FORMULARY (DRUG) REVIEW

The Formulary review process in the Master Review Tool ensures compliance with EHB and checks for discrimination by counting drugs in each USP category and class.

1. Open the Qualified Health Plan Application State Review Tools folder and run the Drug Tool for the drug lists you wish to evaluate. You must copy/paste the information from each issuer's Category Class Count Report one at a time, so be sure to save the Drug Tool after each evaluation with a unique filename, e.g., by issuer ID. For more information on running the Drug Tool, see section VI. Formulary (Drug) Tool in the *QHP Application State Review Tools User Guide: Loading the Data*.



This user has run and saved the Drug Tool for three issuers' drug lists (18637, 30942, and 33674).

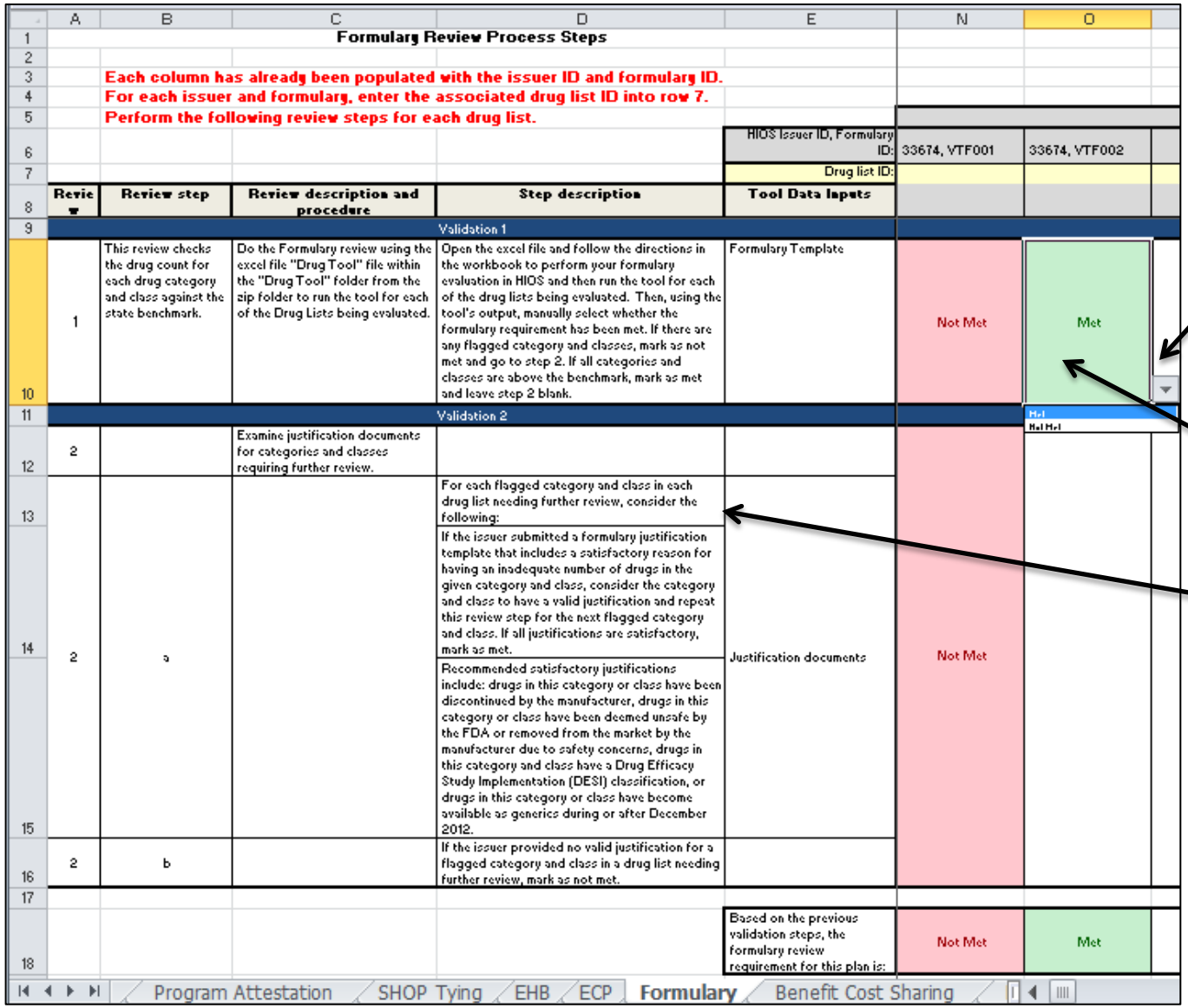
2. Open the Drug Tool *Output* tab for the issuer's drug list you wish to evaluate.

Total Number of Classes with the Count Standard Not Met				18
Category	**Class**	**Drug List Count**	**Benchmark Count**	**Count Standard Met?**
Analgesics	Nonsteroidal Anti-inflammatory Drugs	19	20	No
Analgesics	Opioid Analgesics, Long-acting	11	11	Yes
Analgesics	Opioid Analgesics, Short-acting	11	11	Yes
Anesthetics	Local Anesthetics	3	3	Yes
Anti-Addiction/Substance Abuse Treatment Agents	Alcohol Deterrents/Anti-craving	3	3	Yes
Anti-Addiction/Substance Abuse Treatment Agents	Opioid Antagonists	3	3	Yes
Anti-Addiction/Substance Abuse Treatment Agents	Smoking Cessation Agents	3	3	Yes
Antibacterials	Aminoglycosides	9	9	Yes
Antibacterials	Antibacterials, Other	19	20	No
Antibacterials	Beta-lactam, Cephalosporins	18	18	Yes
Antibacterials	Beta-lactam, Other	5	5	Yes
Antibacterials	Beta-lactam, Penicillins	12	12	Yes
Antibacterials	Macrolides	5	5	Yes
Antibacterials	Quinolones	7	8	No

structions | Start Sheet | Output

Open the completed Drug Tool *Output* tab to see the issuer's drug list you wish to review.

3. Using the data in the Drug Tool *Output* tab, go to the Master Review Tool *Formulary* tab, and use the drop-down menus to indicate if an issuer's drug list has met the formulary requirement.



	A	B	C	D	E	N	O
1				**Formulary Review Process Steps**			
2							
3		**Each column has already been populated with the issuer ID and formulary ID.**					
4		**For each issuer and formulary, enter the associated drug list ID into row 7.**					
5		**Perform the following review steps for each drug list.**					
6					HIOS Issuer ID, Formulary ID:	33674, VTF001	33674, VTF002
7					Drug list ID:		
8	**Review**	**Review step**	**Review description and procedure**	**Step description**	**Tool Data Inputs**		
9				Validation 1			
10	1	This review checks the drug count for each drug category and class against the state benchmark.	Do the Formulary review using the excel file "Drug Tool" file within the "Drug Tool" folder from the zip folder to run the tool for each of the Drug Lists being evaluated.	Open the excel file and follow the directions in the workbook to perform your formulary evaluation in HIOS and then run the tool for each of the drug lists being evaluated. Then, using the tool's output, manually select whether the formulary requirement has been met. If there are any flagged category and classes, mark as not met and go to step 2. If all categories and classes are above the benchmark, mark as met and leave step 2 blank.	Formulary Template	Not Met	Met
11				Validation 2			Met / Not Met
12	2		Examine justification documents for categories and classes requiring further review.				
13				For each flagged category and class in each drug list needing further review, consider the following:			
14	2	a		If the issuer submitted a formulary justification template that includes a satisfactory reason for having an inadequate number of drugs in the given category and class, consider the category and class to have a valid justification and repeat this review step for the next flagged category and class. If all justifications are satisfactory, mark as met.	Justification documents	Not Met	
15				Recommended satisfactory justifications include: drugs in this category or class have been discontinued by the manufacturer, drugs in this category or class have been deemed unsafe by the FDA or removed from the market by the manufacturer due to safety concerns, drugs in this category and class have a Drug Efficacy Study Implementation (DESI) classification, or drugs in this category or class have become available as generics during or after December 2012.			
16	2	b		If the issuer provided no valid justification for a flagged category and class in a drug list needing further review, mark as not met.			
17							
18					Based on the previous validation steps, the formulary review requirement for this plan is:	Not Met	Met

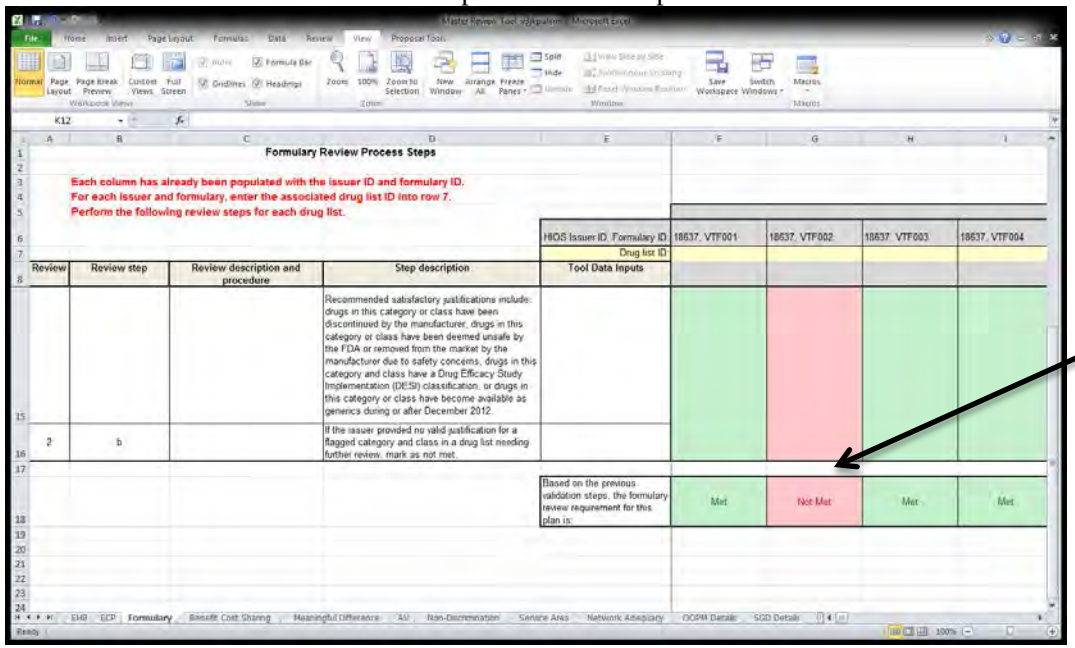
Program Attestation | SHOP Tying | EHB | ECP | **Formulary** | Benefit Cost Sharing

Use the *drop-down menus* to indicate **Met** or **Not Met** for each issuer's drug list.

If an issuer's drug list categories and classes are above the benchmark, mark **Met** and skip the remaining steps.

If an issuer's drug list has any flagged Category and Classes, mark **Not Met**, proceed to step 2, and follow the step descriptions in cells D13-15 for justifications.

4. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Formulary* requirements.



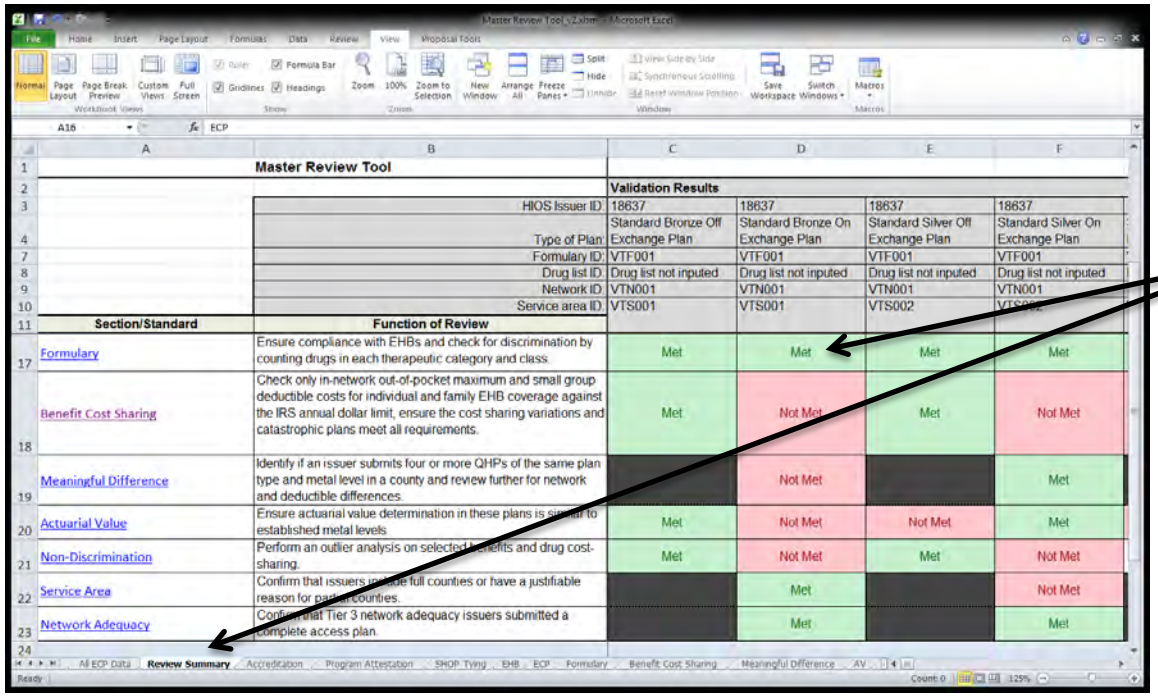
Formulary Review Process Steps

Each column has already been populated with the issuer ID and formulary ID.
For each issuer and formulary, enter the associated drug list ID into row 7.
Perform the following review steps for each drug list.

				HIOS Issuer ID_Formulary ID	18637_VTF001	18637_VTF002	18637_VTF003	18637_VTF004
				Drug list ID				
Review	Review step	Review description and procedure	Step description	Tool Data Inputs				
			Recommended satisfactory justifications include: drugs in this category or class have been discontinued by the manufacturer, drugs in this category or class have been deemed unsafe by the FDA or removed from the market by the manufacturer due to safety concerns, drugs in this category and class have a Drug Efficacy Study Implementation (DESI) classification, or drugs in this category or class have become available as generics during or after December 2012.					
2	b		If the issuer provided no valid justification for a flagged category and class in a drug list needing further review, mark as not met.					
				Based on the previous validation steps, the formulary review requirement for this plan is:	Met	Not Met	Met	Met

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

5. After you have manually populated **Met** or **Not Met** for each issuer's drug list in the Master Review Tool *Formulary* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



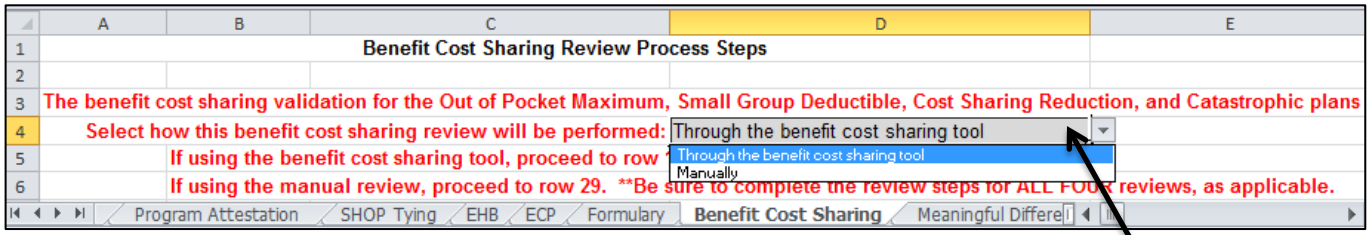
	A	B	C	D	E	F
1		**Master Review Tool**				
2			**Validation Results**			
3		HIOS Issuer ID	18637	18637	18637	18637
4		Type of Plan	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
7		Formulary ID	VTF001	VTF001	VTF001	VTF001
8		Drug list ID	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
9		Network ID	VTN001	VTN001	VTN001	VTN001
10		Service area ID	VTS001	VTS001	VTS002	VTS002
11	**Section/Standard**	**Function of Review**				
17	Formulary	Ensure compliance with EHBs and check for discrimination by counting drugs in each therapeutic category and class.	Met	Met	Met	Met
18	Benefit Cost Sharing	Check only in-network out-of-pocket maximum and small group deductible costs for individual and family EHB coverage against the IRS annual dollar limit, ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Not Met	Met	Not Met
19	Meaningful Difference	Identify if an issuer submits four or more QHPs of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met
20	Actuarial Value	Ensure actuarial value determination in these plans is similar to established metal levels.	Met	Not Met	Not Met	Met
21	Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
22	Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
23	Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan.		Met		Met
24						

Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

6. Save the Master Review Tool after you have completed the Formulary review.

VIII: COST SHARING REVIEW

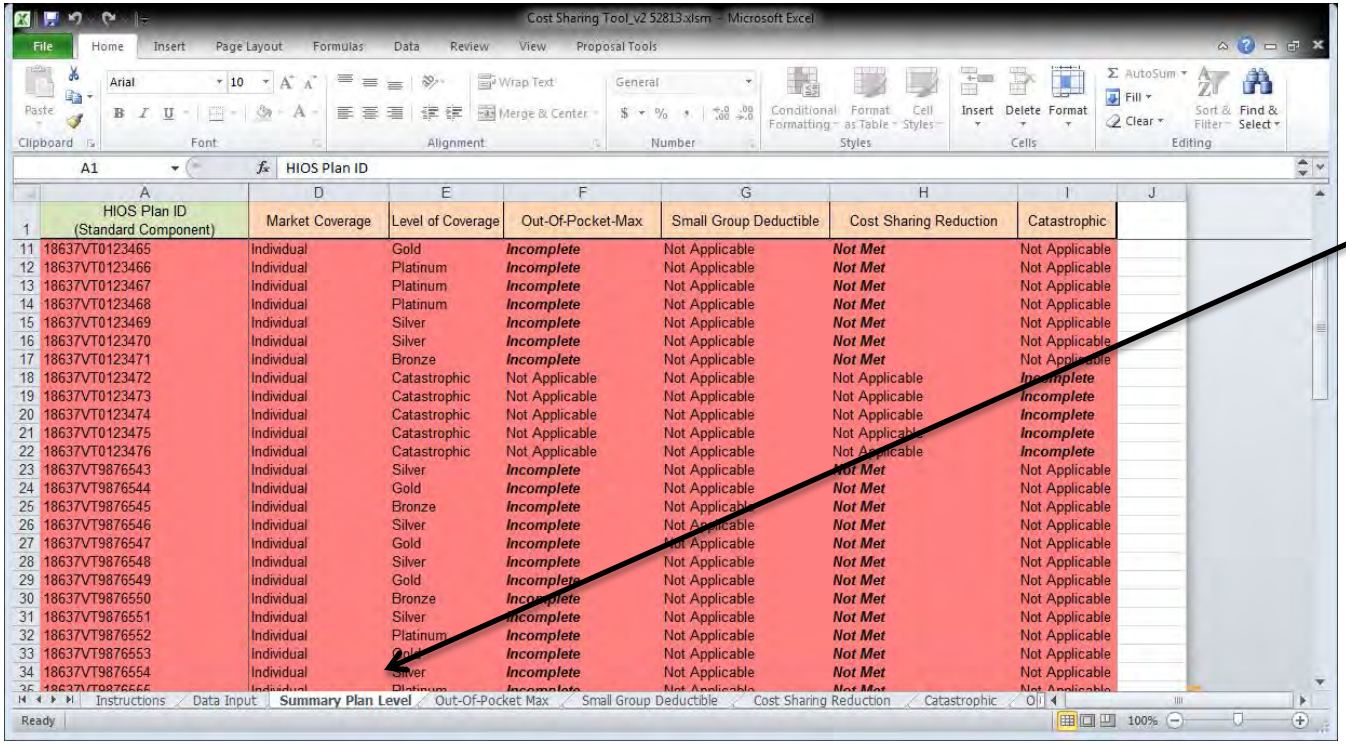
1. Open the Qualified Health Plan Application State Review Tools folder and run the Cost Sharing Tool for all the plans you wish to evaluate. For more information on running the Cost Sharing Tool, see section V. Cost Sharing Tool in the *QHP Application State Review Tools User Guide: Loading the Data*.
2. If you decide to use the Benefit Cost Sharing stand-alone tool, review the validation steps in the Master Review Tool *Benefit Cost Sharing* tab to better understand the logic behind the Cost Sharing Tool or to see where you can submit justifications.
3. Use the *drop-down menu* in cell D4 to select how you will perform the review.



Open the Master Review Tool *Benefit Cost Sharing* tab to see the review description.

Use the *drop-down menu* in cell D4 to select how you will perform the review

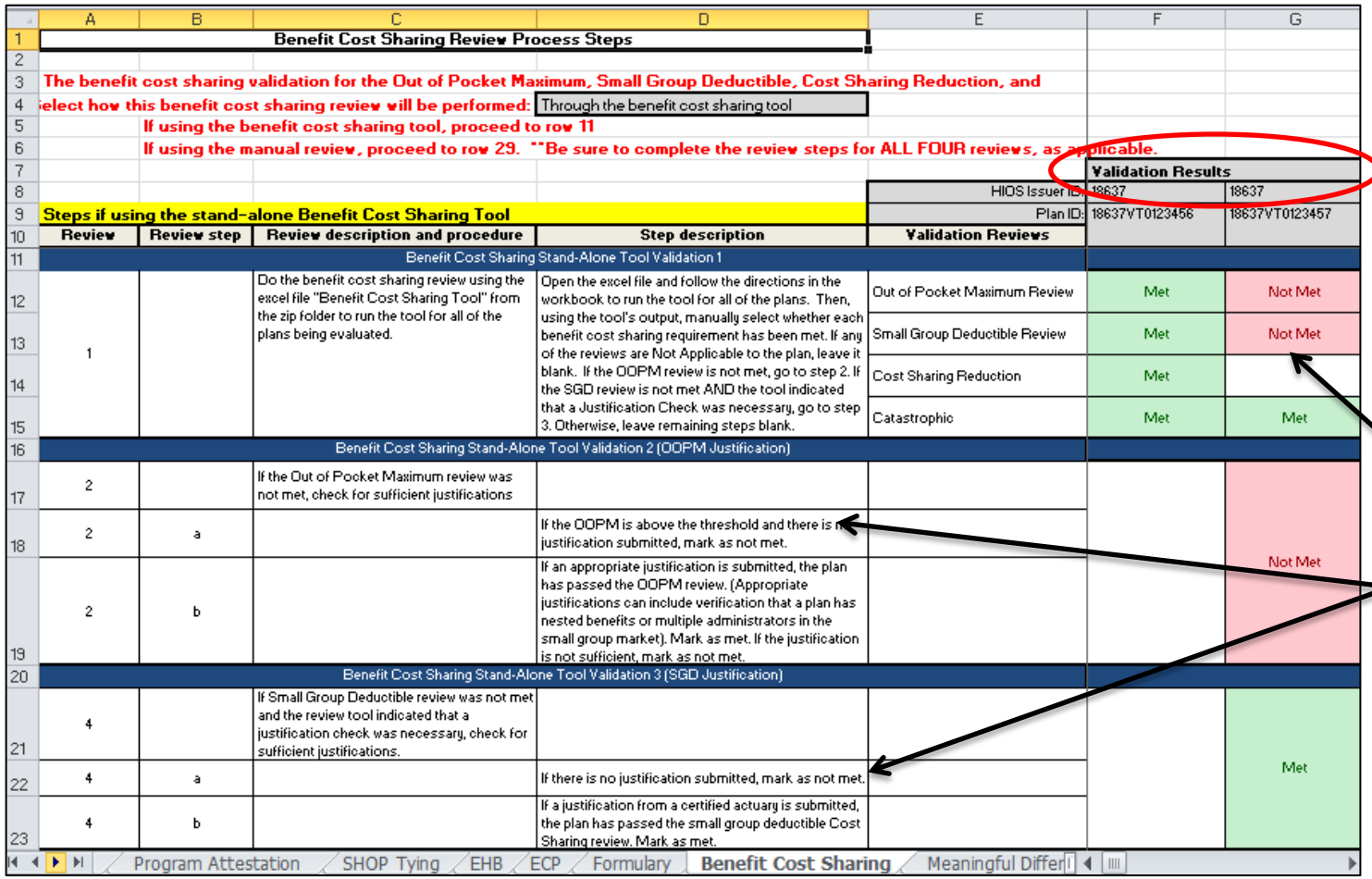
4. Open the Cost Sharing Tool *Summary Plan Level* tab to see the issuer's plans you wish to review.



HIOS Plan ID (Standard Component)	Market Coverage	Level of Coverage	Out-Of-Pocket-Max	Small Group Deductible	Cost Sharing Reduction	Catastrophic
18637VT0123465	Individual	Gold	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123466	Individual	Platinum	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123467	Individual	Platinum	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123468	Individual	Platinum	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123469	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123470	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123471	Individual	Bronze	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT0123472	Individual	Catastrophic	Not Applicable	Not Applicable	Not Applicable	Incomplete
18637VT0123473	Individual	Catastrophic	Not Applicable	Not Applicable	Not Applicable	Incomplete
18637VT0123474	Individual	Catastrophic	Not Applicable	Not Applicable	Not Applicable	Incomplete
18637VT0123475	Individual	Catastrophic	Not Applicable	Not Applicable	Not Applicable	Incomplete
18637VT0123476	Individual	Catastrophic	Not Applicable	Not Applicable	Not Applicable	Incomplete
18637VT9876543	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876544	Individual	Gold	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876545	Individual	Bronze	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876546	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876547	Individual	Gold	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876548	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876549	Individual	Gold	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876550	Individual	Bronze	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876551	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876552	Individual	Platinum	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876553	Individual	Gold	Incomplete	Not Applicable	Not Met	Not Applicable
18637VT9876554	Individual	Silver	Incomplete	Not Applicable	Not Met	Not Applicable

5. Using the data in the Cost Sharing Tool *Summary Plan Level* tab, go to the Master Review Tool *Benefit Cost Sharing* tab and use the drop-down menus in the *Validation Results* columns to indicate if an issuer's plan has met the benefit cost-sharing requirements. Please note this does not include the process steps/review for those plans intending to only offer coverage to individuals (self-only).

   a. Leave a validation cell blank if any review was not applicable to a plan.
   b. If the OOPM review is **Not Met**, got to step two.
   c. If the SGD review is **Not Met** AND the Cost Sharing Tool *Summary Plan Level* tab indicated that a justification check was necessary, go to step three. Otherwise, you can skip all other validation steps.



	A	B	C	D	E	F	G
1	Benefit Cost Sharing Review Process Steps						
2							
3	The benefit cost sharing validation for the Out of Pocket Maximum, Small Group Deductible, Cost Sharing Reduction, and						
4	elect how this benefit cost sharing review will be performed:			Through the benefit cost sharing tool			
5		If using the benefit cost sharing tool, proceed to row 11					
6		If using the manual review, proceed to row 29. **Be sure to complete the review steps for ALL FOUR reviews, as applicable.					
7						Validation Results	
8					HIOS Issuer ID:	18637	18637
9	Steps if using the stand-alone Benefit Cost Sharing Tool				Plan ID:	18637VT0123456	18637VT0123457
10	Review	Review step	Review description and procedure	Step description	Validation Reviews		
11	Benefit Cost Sharing Stand-Alone Tool Validation 1						
12	1		Do the benefit cost sharing review using the excel file "Benefit Cost Sharing Tool" from the zip folder to run the tool for all of the plans being evaluated.	Open the excel file and follow the directions in the workbook to run the tool for all of the plans. Then, using the tool's output, manually select whether each benefit cost sharing requirement has been met. If any of the reviews are Not Applicable to the plan, leave it blank. If the OOPM review is not met, go to step 2. If the SGD review is not met AND the tool indicated that a Justification Check was necessary, go to step 3. Otherwise, leave remaining steps blank.	Out of Pocket Maximum Review	Met	Not Met
13					Small Group Deductible Review	Met	Not Met
14					Cost Sharing Reduction	Met	
15					Catastrophic	Met	Met
16	Benefit Cost Sharing Stand-Alone Tool Validation 2 (OOPM Justification)						
17	2		If the Out of Pocket Maximum review was not met, check for sufficient justifications				Not Met
18	2	a		If the OOPM is above the threshold and there is n justification submitted, mark as not met.			
19	2	b		If an appropriate justification is submitted, the plan has passed the OOPM review. (Appropriate justifications can include verification that a plan has nested benefits or multiple administrators in the small group market). Mark as met. If the justification is not sufficient, mark as not met.			
20	Benefit Cost Sharing Stand-Alone Tool Validation 3 (SGD Justification)						
21	4		If Small Group Deductible review was not met and the review tool indicated that a justification check was necessary, check for sufficient justifications.				Met
22	4	a		If there is no justification submitted, mark as not met.			
23	4	b		If a justification from a certified actuary is submitted, the plan has passed the small group deductible Cost Sharing review. Mark as met.			

Program Attestation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Differ

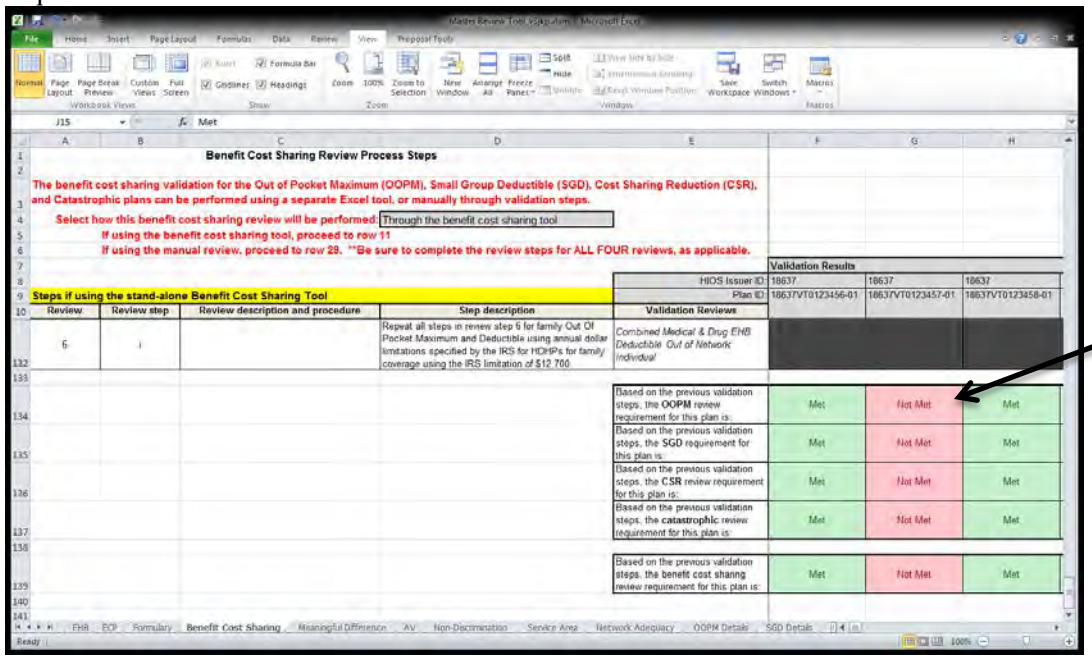
Use the *drop-down menus* to indicate **Met** or **Not Met** for each cost-sharing requirement.

If the requirement is **Met**, you can skip all other validation steps.

If a review was not applicable to a plan, leave the cell blank.

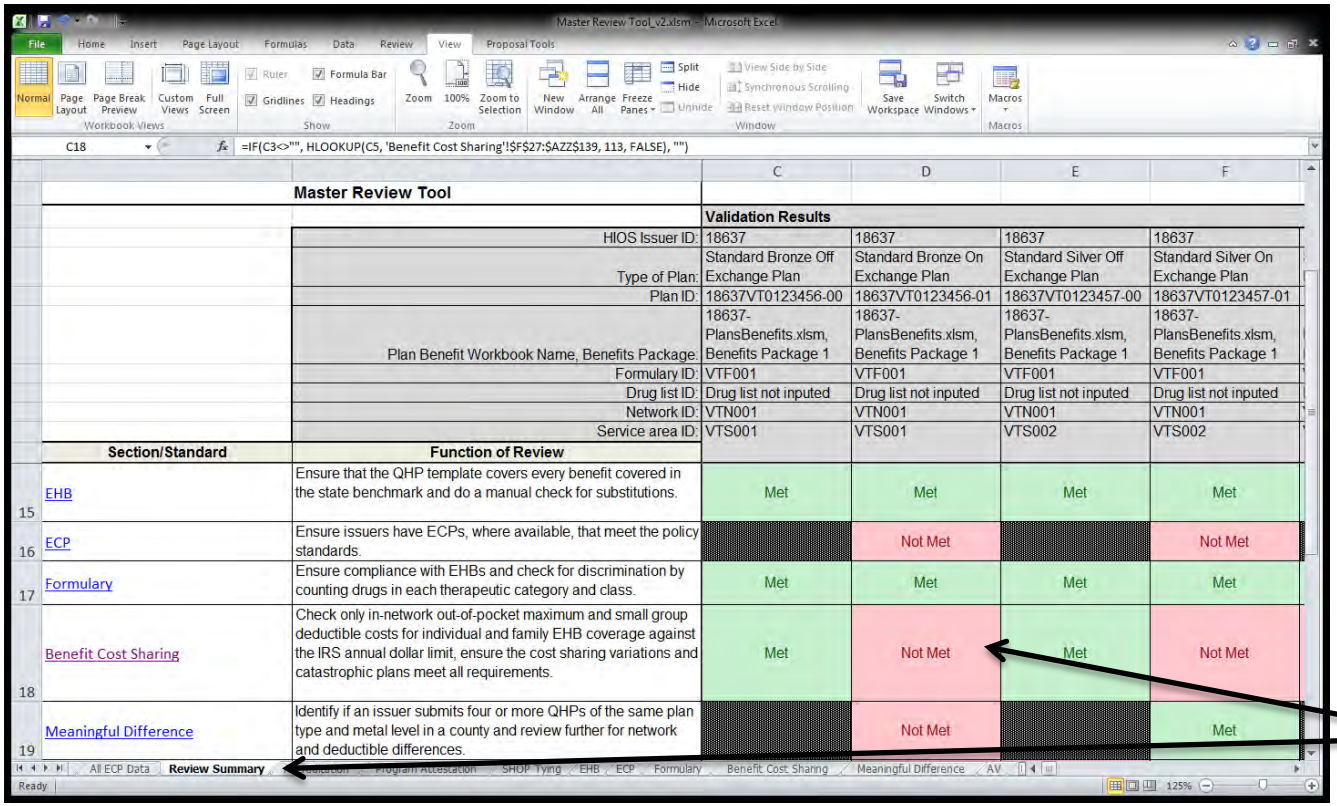
If a requirement is **Not Met**, follow the validation step descriptions in cells D18-19 for OOPM justification and cells D22-23 for SGD justifications.

7. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Cost Sharing* requirements.



The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

6. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Benefit Cost Sharing* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool_v2.xlsm - Microsoft Excel

C18 =IF(C3<>"", HLOOKUP(C5, 'Benefit Cost Sharing'!$F$27:$AZZ$139, 113, FALSE), "")

			C	D	E	F
	Master Review Tool					
			Validation Results			
		HIOS Issuer ID:	18637	18637	18637	18637
		Type of Plan:	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
		Plan ID:	18637VT0123456-00	18637VT0123456-01	18637VT0123457-00	18637VT0123457-01
		Plan Benefit Workbook Name, Benefits Package:	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1	18637-PlansBenefits.xlsm, Benefits Package 1
		Formulary ID:	VTF001	VTF001	VTF001	VTF001
		Drug list ID:	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
		Network ID:	VTN001	VTN001	VTN001	VTN001
		Service area ID:	VTS001	VTS001	VTS002	VTS002
	Section/Standard	**Function of Review**				
15	EHB	Ensure that the QHP template covers every benefit covered in the state benchmark and do a manual check for substitutions.	Met	Met	Met	Met
16	ECP	Ensure issuers have ECPs, where available, that meet the policy standards.		Not Met		Not Met
17	Formulary	Ensure compliance with EHBs and check for discrimination by counting drugs in each therapeutic category and class.	Met	Met	Met	Met
18	Benefit Cost Sharing	Check only in-network out-of-pocket maximum and small group deductible costs for individual and family EHB coverage against the IRS annual dollar limit, ensure the cost sharing variations and catastrophic plans meet all requirements.	Met	Not Met	Met	Not Met
19	Meaningful Difference	Identify if an issuer submits four or more QHPs of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met

All ECP Data | Review Summary | Program Accessation | SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference | AV

Ready

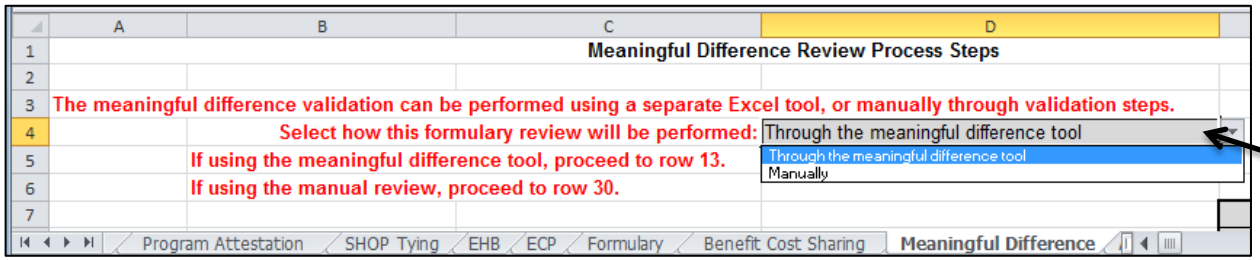
Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

7. Save the Master Review Tool after you have completed the *Benefit Cost Sharing* review.

IX: MEANINGFUL DIFFERENCE REVIEW

The *Meaningful Difference* review process in the Master Review Tool reviews an issuer's QHPs of the same plan type and metal level in a county for substantial differences.

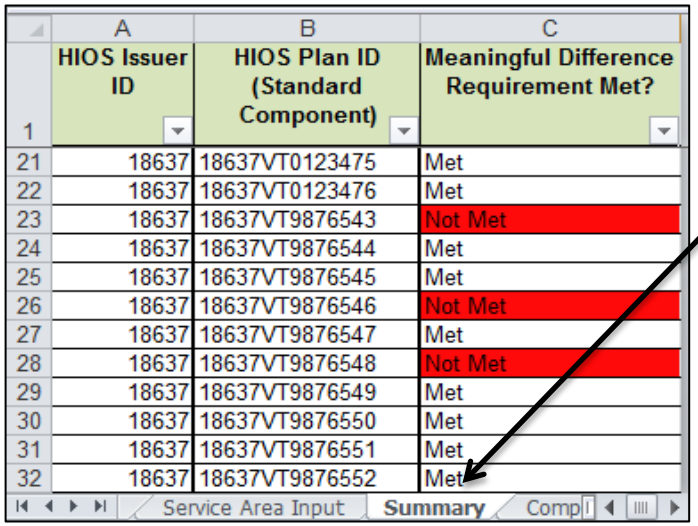
1. Open the Qualified Health Plan Application State Review Tools folder and run the Meaningful Difference Tool for all the plans you wish to evaluate. For more information on running the Meaningful Difference Tool, see section III. Meaningful Difference Tool in the *QHP Application State Review Tools User Guide: Loading the Data*.
2. If you decide to use the Meaningful Difference stand-alone tool, review the validation steps in the Master Review Tool *Meaningful Difference* tab to better understand the logic behind the Meaningful Difference Tool or to see where you can submit justifications.
3. Use the *drop-down menu* in cell D4 to select how you will perform the review.



Open the Master Review Tool *Meaningful Difference* tab to see the review description.

Use the *drop-down menu* in cell D4 to select how you will perform the review.

4. Open the Meaningful Difference Tool *Summary* tab to see the issuer's plans you wish to review.

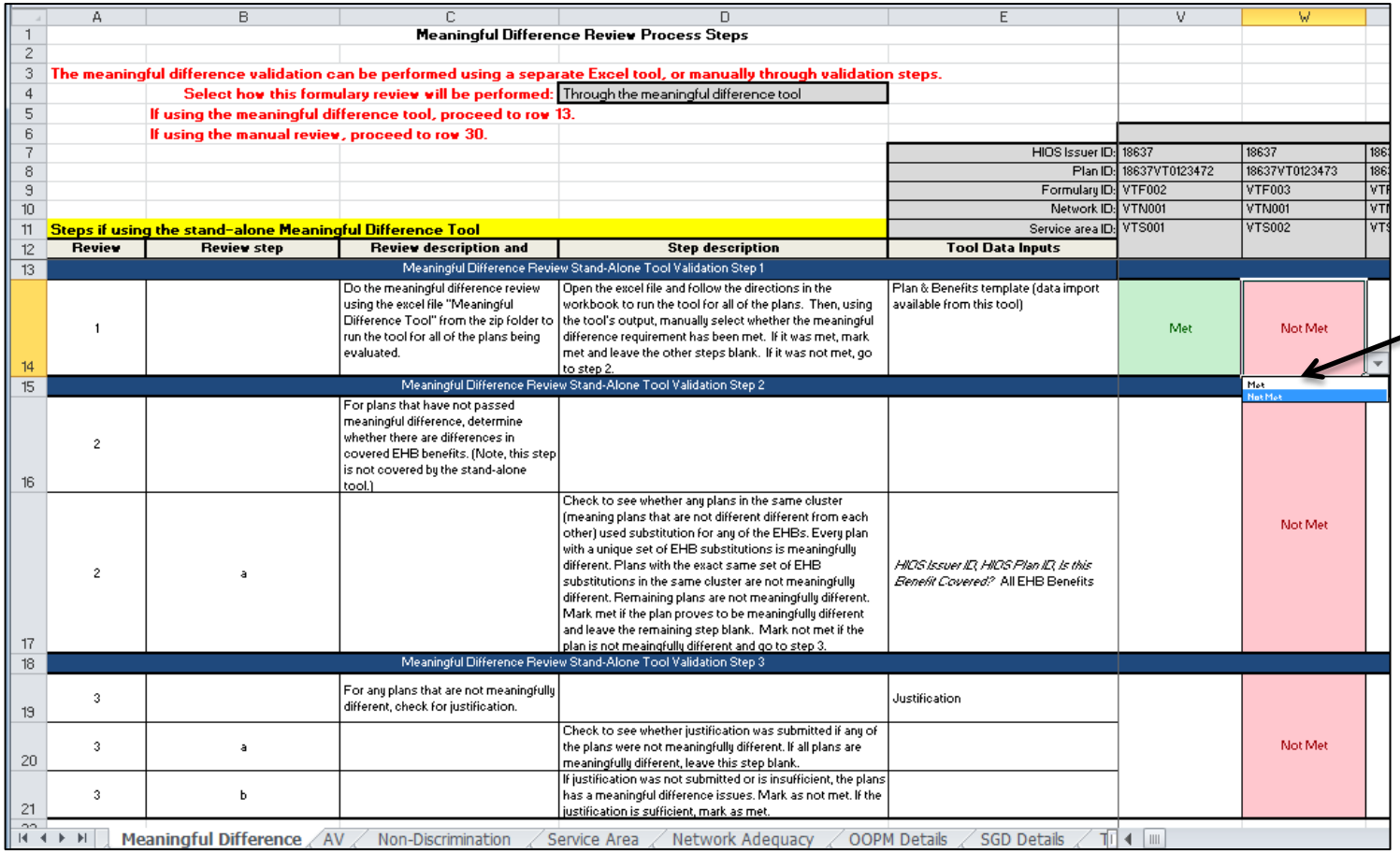


	A	B	C
1	HIOS Issuer ID	HIOS Plan ID (Standard Component)	Meaningful Difference Requirement Met?
21	18637	18637VT0123475	Met
22	18637	18637VT0123476	Met
23	18637	18637VT9876543	Not Met
24	18637	18637VT9876544	Met
25	18637	18637VT9876545	Met
26	18637	18637VT9876546	Not Met
27	18637	18637VT9876547	Met
28	18637	18637VT9876548	Not Met
29	18637	18637VT9876549	Met
30	18637	18637VT9876550	Met
31	18637	18637VT9876551	Met
32	18637	18637VT9876552	Met

Service Area Input | Summary | Comp

Open the Meaningful Difference Tool *Summary* tab to see the issuer's plans you wish to evaluate.

5. Using the data in the Meaningful Difference Tool *Summary* tab, go to the Master Review Tool *Meaningful Difference* tab and use the drop-down menus to indicate if an issuer's plan has met the meaningful difference requirement.

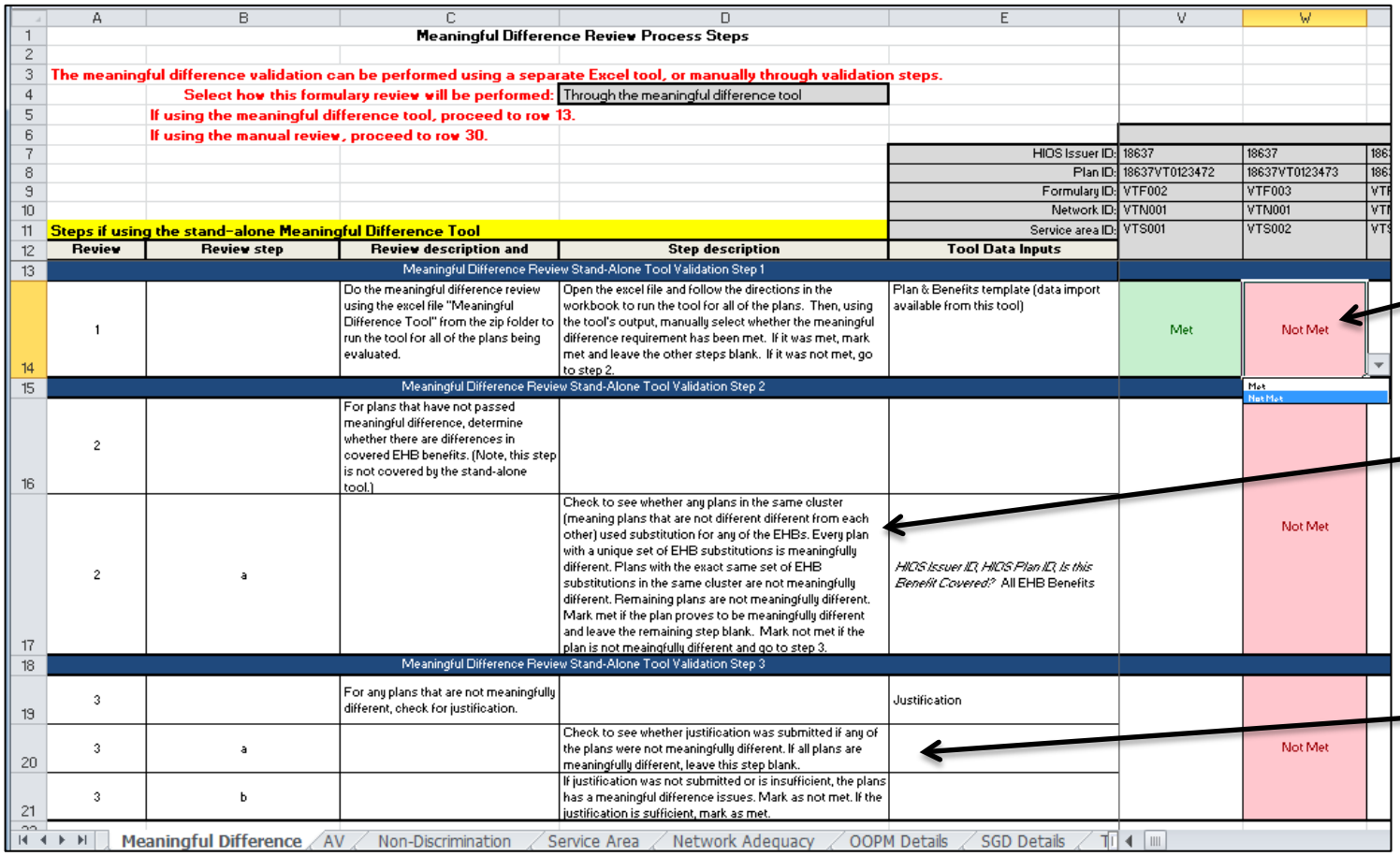


	A	B	C	D	E	V	W
1	**Meaningful Difference Review Process Steps**						
2							
3	**The meaningful difference validation can be performed using a separate Excel tool, or manually through validation steps.**						
4		**Select how this formulary review will be performed:**		Through the meaningful difference tool			
5		**If using the meaningful difference tool, proceed to row 13.**					
6		**If using the manual review, proceed to row 30.**					
7					HIOS Issuer ID:	18637	18637
8					Plan ID:	18637VT0123472	18637VT0123473
9					Formulary ID:	VTF002	VTF003
10					Network ID:	VTN001	VTN001
11	**Steps if using the stand-alone Meaningful Difference Tool**				Service area ID:	VTS001	VTS002
12	**Review**	**Review step**	**Review description and**	**Step description**	**Tool Data Inputs**		
13	Meaningful Difference Review Stand-Alone Tool Validation Step 1						
14	1		Do the meaningful difference review using the excel file "Meaningful Difference Tool" from the zip folder to run the tool for all of the plans being evaluated.	Open the excel file and follow the directions in the workbook to run the tool for all of the plans. Then, using the tool's output, manually select whether the meaningful difference requirement has been met. If it was met, mark met and leave the other steps blank. If it was not met, go to step 2.	Plan & Benefits template (data import available from this tool)	Met	Not Met
15	Meaningful Difference Review Stand-Alone Tool Validation Step 2						Met / Not Met
16	2		For plans that have not passed meaningful difference, determine whether there are differences in covered EHB benefits. (Note, this step is not covered by the stand-alone tool.)				
17	2	a		Check to see whether any plans in the same cluster (meaning plans that are not different different from each other) used substitution for any of the EHBs. Every plan with a unique set of EHB substitutions is meaningfully different. Plans with the exact same set of EHB substitutions in the same cluster are not meaningfully different. Remaining plans are not meaningfully different. Mark met if the plan proves to be meaningfully different and leave the remaining step blank. Mark not met if the plan is not meaningfully different and go to step 3.	*HIOS Issuer ID; HIOS Plan ID; Is this Benefit Covered?* All EHB Benefits		Not Met
18	Meaningful Difference Review Stand-Alone Tool Validation Step 3						
19	3		For any plans that are not meaningfully different, check for justification.		Justification		
20	3	a		Check to see whether justification was submitted if any of the plans were not meaningfully different. If all plans are meaningfully different, leave this step blank.			Not Met
21	3	b		If justification was not submitted or is insufficient, the plans has a meaningful difference issues. Mark as not met. If the justification is sufficient, mark as met.			

Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM Details | SGD Details

Use the *drop-down menus* to indicate **Met** or **Not Met** for each requirement.

If meaningful difference is **Met**, you can skip validation steps 2 and 3.



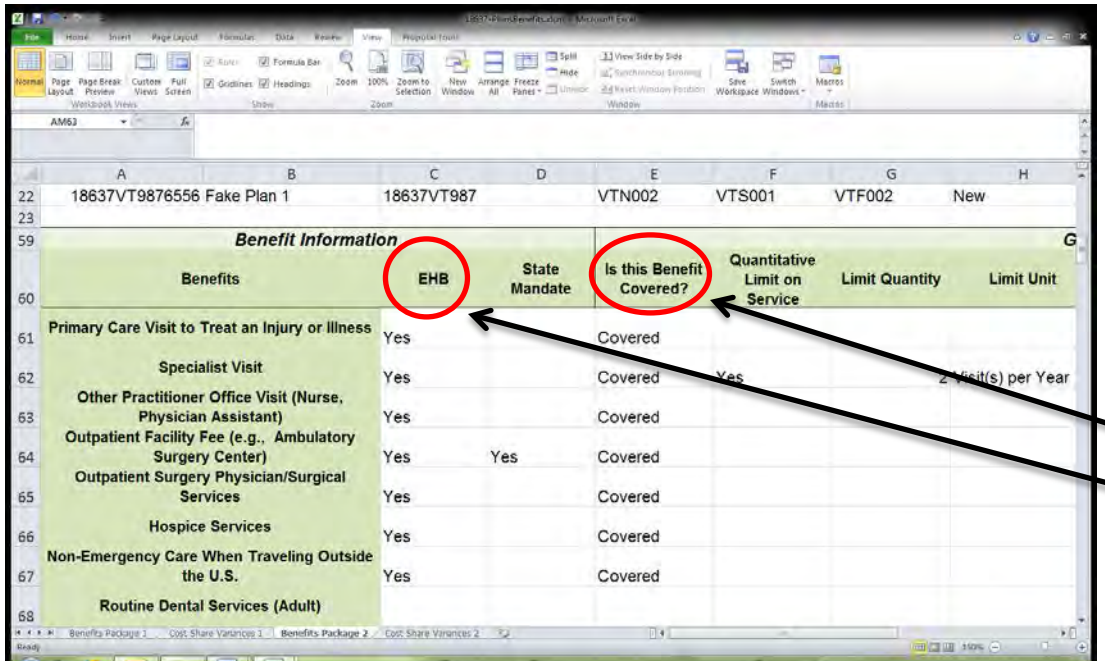
	A	B	C	D	E	V	W
1				**Meaningful Difference Review Process Steps**			
2							
3	**The meaningful difference validation can be performed using a separate Excel tool, or manually through validation steps.**						
4		**Select how this formulary review will be performed:**		Through the meaningful difference tool			
5		**If using the meaningful difference tool, proceed to row 13.**					
6		**If using the manual review, proceed to row 30.**					
7					HIOS Issuer ID:	18637	18637
8					Plan ID:	18637VT0123472	18637VT0123473
9					Formulary ID:	VTF002	VTF003
10					Network ID:	VTN001	VTN001
11	**Steps if using the stand-alone Meaningful Difference Tool**				Service area ID:	VTS001	VTS002
12	**Review**	**Review step**	**Review description and**	**Step description**	**Tool Data Inputs**		
13	Meaningful Difference Review Stand-Alone Tool Validation Step 1						
14	1		Do the meaningful difference review using the excel file "Meaningful Difference Tool" from the zip folder to run the tool for all of the plans being evaluated.	Open the excel file and follow the directions in the workbook to run the tool for all of the plans. Then, using the tool's output, manually select whether the meaningful difference requirement has been met. If it was met, mark met and leave the other steps blank. If it was not met, go to step 2.	Plan & Benefits template (data import available from this tool)	Met	Not Met
15	Meaningful Difference Review Stand-Alone Tool Validation Step 2						Met / Not Met
16	2		For plans that have not passed meaningful difference, determine whether there are differences in covered EHB benefits. (Note, this step is not covered by the stand-alone tool.)				
17	2	a		Check to see whether any plans in the same cluster (meaning plans that are not different different from each other) used substitution for any of the EHBs. Every plan with a unique set of EHB substitutions is meaningfully different. Plans with the exact same set of EHB substitutions in the same cluster are not meaningfully different. Remaining plans are not meaningfully different. Mark met if the plan proves to be meaningfully different and leave the remaining step blank. Mark not met if the plan is not meaningfully different and go to step 3.	*HIOS Issuer ID, HIOS Plan ID, Is this Benefit Covered?* All EHB Benefits		Not Met
18	Meaningful Difference Review Stand-Alone Tool Validation Step 3						
19	3		For any plans that are not meaningfully different, check for justification.		Justification		
20	3	a		Check to see whether justification was submitted if any of the plans were not meaningfully different. If all plans are meaningfully different, leave this step blank.			Not Met
21	3	b		If justification was not submitted or is insufficient, the plans has a meaningful difference issues. Mark as not met. If the justification is sufficient, mark as met.			

Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM Details | SGD Details

If meaningful difference is **Not Met**, proceed to validation step 2, and follow the validation step descriptions in cell D17 for EHB benefits difference (see below).

If applicable, proceed to step 3, and follow the validation step descriptions in cells D20-21 for meaningful difference justification.

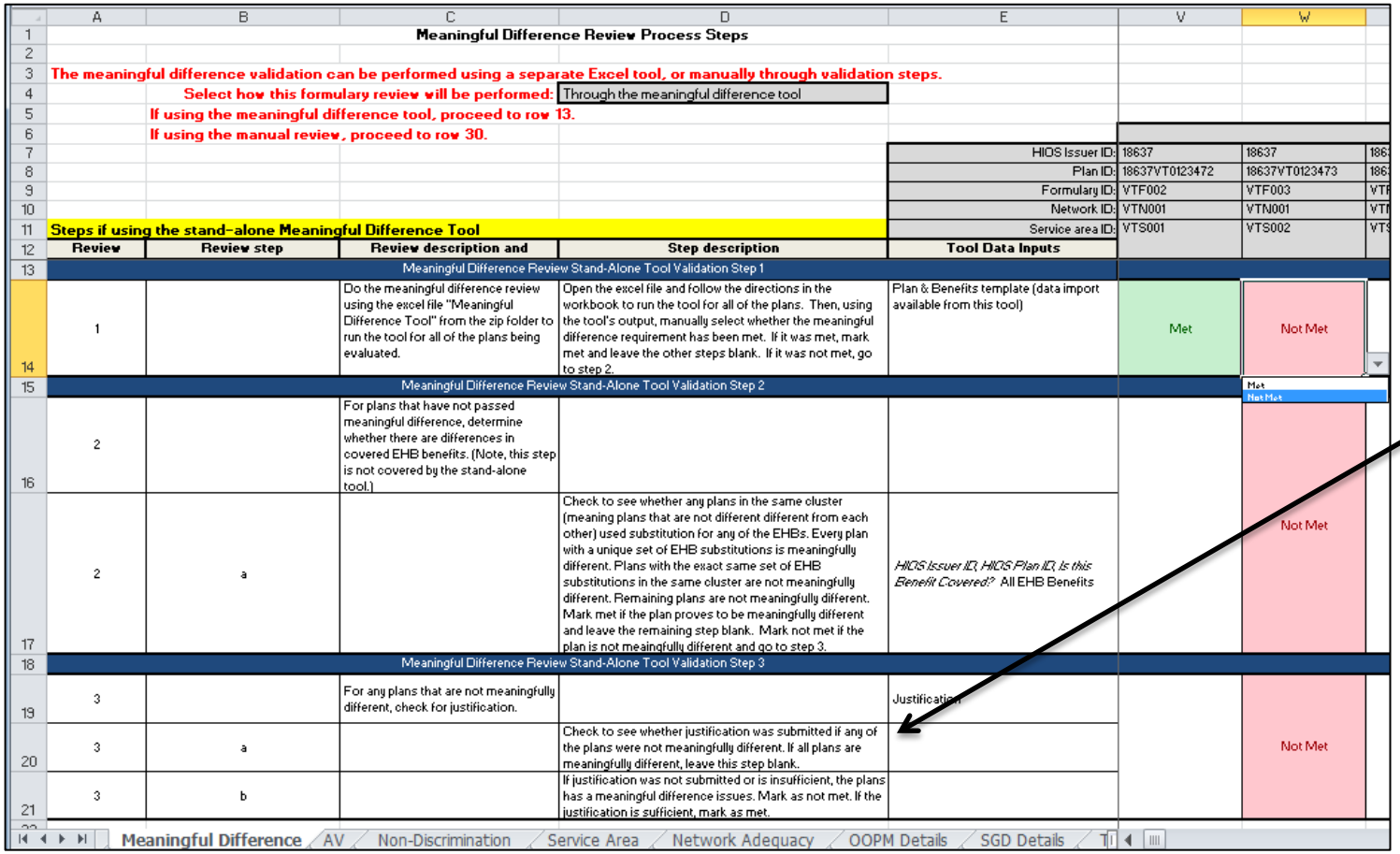
6. Using the Benefits template, check to see whether any plan in the same cluster, (a cluster being a group of plans that are not different from each other), used a substitution for any of the EHBs.
   a. Every plan with a unique set of EHB substitutions is meaningfully different.
   b. Plans with the exact same set of EHB substitutions in the same cluster are not meaningfully different.
   c. Remaining plans are not meaningfully different.



	A	B	C	D	E	F	G	H
22	18637VT9876556 Fake Plan 1		18637VT987		VTN002	VTS001	VTF002	New
23								
59		***Benefit Information***						G
60		**Benefits**	**EHB**	**State Mandate**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**
61		**Primary Care Visit to Treat an Injury or Illness**	Yes		Covered			
62		**Specialist Visit**	Yes		Covered	Yes		2 Visit(s) per Year
63		**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Yes		Covered			
64		**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Yes	Yes	Covered			
65		**Outpatient Surgery Physician/Surgical Services**	Yes		Covered			
66		**Hospice Services**	Yes		Covered			
67		**Non-Emergency Care When Traveling Outside the U.S.**	Yes		Covered			
68		**Routine Dental Services (Adult)**						

Using the Plans and Benefits template data for *EHB* and *Is this Benefit Covered?*, check to see whether any plan in the same cluster, (a cluster being a group of plans that are not different from each other), used a substitution for any of the EHBs.

7. Mark **Met** if the plan proves to be meaningfully different and leave the remaining blank. Mark **Not Met** if the plan is not meaningfully different and proceed to step 3.



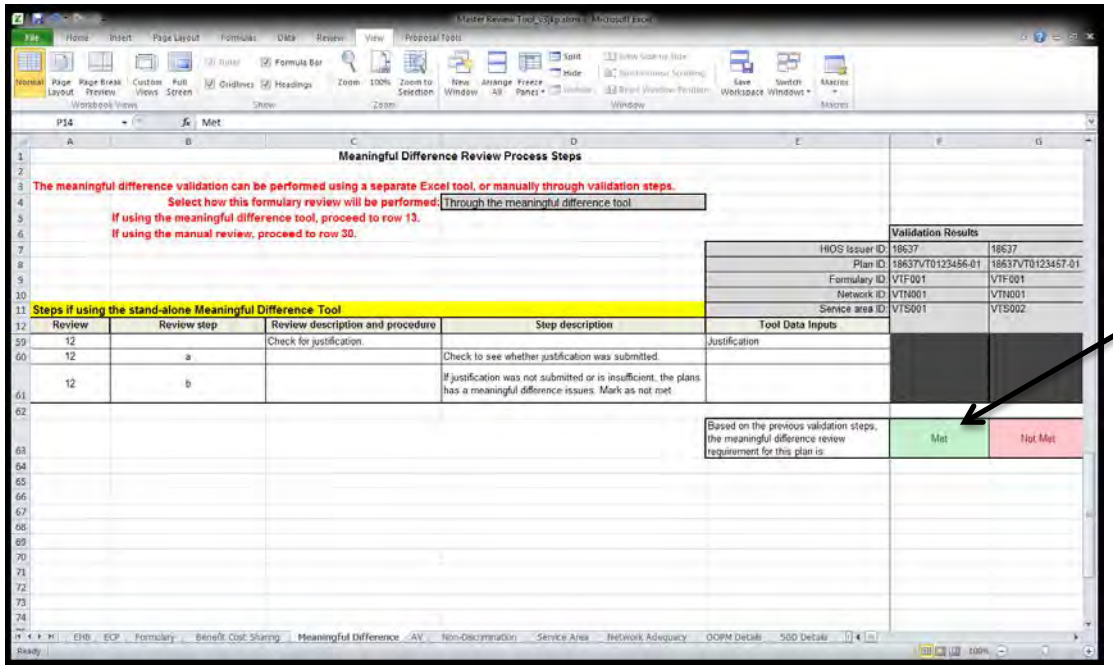
	A	B	C	D	E	V	W
1			Meaningful Difference Review Process Steps				
2							
3	The meaningful difference validation can be performed using a separate Excel tool, or manually through validation steps.						
4		Select how this formulary review will be performed:		Through the meaningful difference tool			
5		If using the meaningful difference tool, proceed to row 13.					
6		If using the manual review, proceed to row 30.					
7					HIOS Issuer ID:	18637	18637
8					Plan ID:	18637VT0123472	18637VT0123473
9					Formulary ID:	VTF002	VTF003
10					Network ID:	VTN001	VTN001
11	Steps if using the stand-alone Meaningful Difference Tool				Service area ID:	VTS001	VTS002
12	Review	Review step	Review description and	Step description	Tool Data Inputs		
13	Meaningful Difference Review Stand-Alone Tool Validation Step 1						
14	1		Do the meaningful difference review using the excel file "Meaningful Difference Tool" from the zip folder to run the tool for all of the plans being evaluated.	Open the excel file and follow the directions in the workbook to run the tool for all of the plans. Then, using the tool's output, manually select whether the meaningful difference requirement has been met. If it was met, mark met and leave the other steps blank. If it was not met, go to step 2.	Plan & Benefits template (data import available from this tool)	Met	Not Met
15	Meaningful Difference Review Stand-Alone Tool Validation Step 2						Met / Not Met
16	2		For plans that have not passed meaningful difference, determine whether there are differences in covered EHB benefits. (Note, this step is not covered by the stand-alone tool.)				
17	2	a		Check to see whether any plans in the same cluster (meaning plans that are not different different from each other) used substitution for any of the EHBs. Every plan with a unique set of EHB substitutions is meaningfully different. Plans with the exact same set of EHB substitutions in the same cluster are not meaningfully different. Remaining plans are not meaningfully different. Mark met if the plan proves to be meaningfully different and leave the remaining step blank. Mark not met if the plan is not meaningfully different and go to step 3.	*HIOS Issuer ID; HIOS Plan ID; Is this Benefit Covered?* All EHB Benefits		Not Met
18	Meaningful Difference Review Stand-Alone Tool Validation Step 3						
19	3		For any plans that are not meaningfully different, check for justification.		Justification		
20	3	a		Check to see whether justification was submitted if any of the plans were not meaningfully different. If all plans are meaningfully different, leave this step blank.			Not Met
21	3	b		If justification was not submitted or is insufficient, the plans has a meaningful difference issues. Mark as not met. If the justification is sufficient, mark as met.			

Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM Details | SGD Details

Mark **Met** if the plan proves to be meaningfully different and leave the remaining blank.

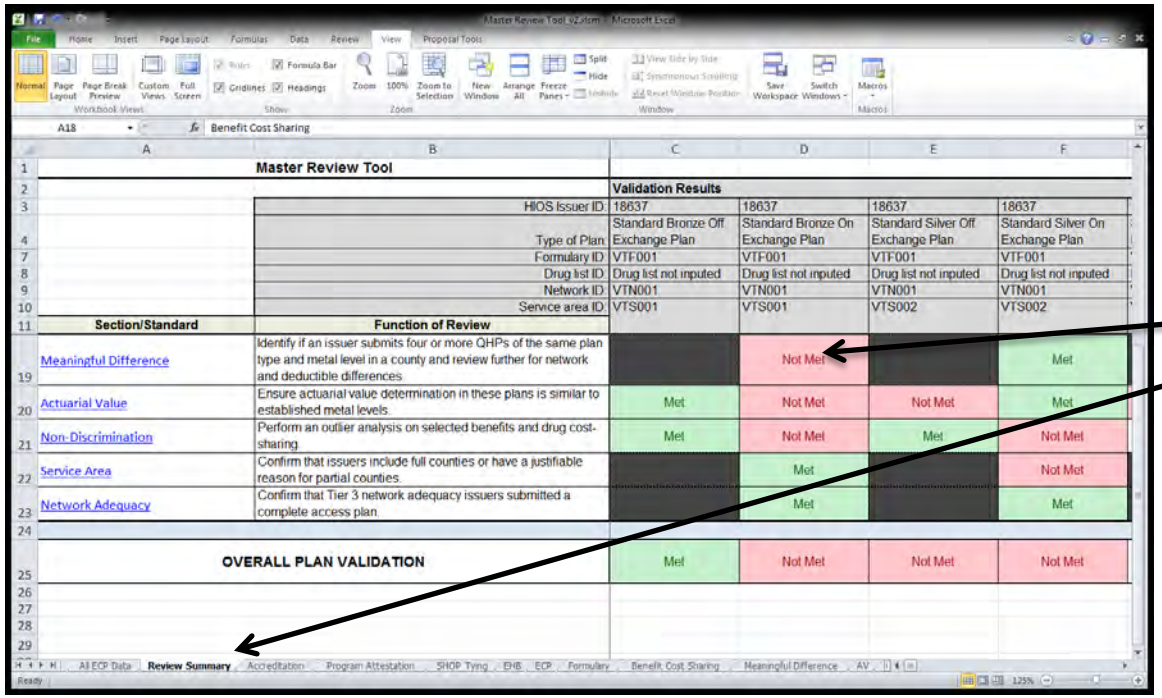
Mark **Not Met** if the plan is not meaningfully different and proceed to step 3.

8. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Meaningful Difference* requirements.



The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

9. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Meaningful Difference* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



	A	B	C	D	E	F
1	Master Review Tool					
2			Validation Results			
3		HIOS Issuer ID	18637	18637	18637	18637
4		Type of Plan	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
7		Formulary ID	VTF001	VTF001	VTF001	VTF001
8		Drug list ID	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
9		Network ID	VTN001	VTN001	VTN001	VTN001
10		Service area ID	VTS001	VTS001	VTS002	VTS002
11	Section/Standard	Function of Review				
19	Meaningful Difference	Identify if an issuer submits four or more QHPs of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met
20	Actuarial Value	Ensure actuarial value determination in these plans is similar to established metal levels.	Met	Not Met	Not Met	Met
21	Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
22	Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
23	Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan.		Met		Met
24						
25	OVERALL PLAN VALIDATION		Met	Not Met	Not Met	Not Met
26						
27						
28						
29						

Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

10. Save the Master Review Tool after you have completed the *Meaningful Difference* review.

X: ACTUARIAL VALUE (AV) REVIEW

The *Actuarial Value (AV)* review verifies that QHPs meet applicable AV standards, consistent with Federal rulemaking.

1. **Use the Unified Rate Review and Plans and Benefits Templates to complete the *AV* review.**

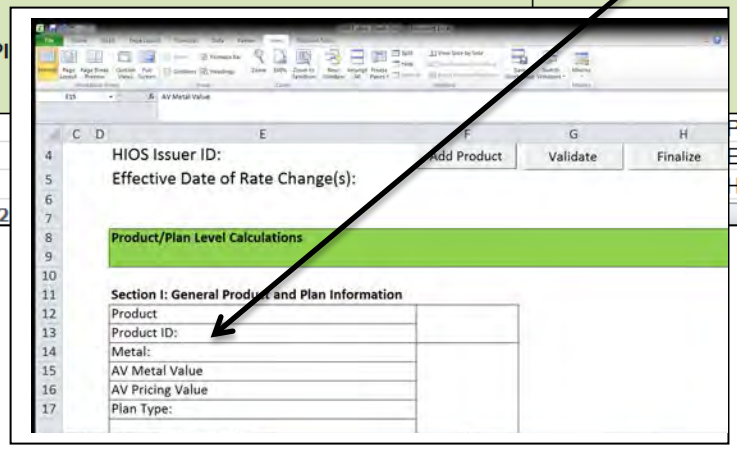
	A	B	C	D	E	F	G	H
1	Actuarial Value Review Process Steps							
2						Validation Results		
3					HIOS Issuer ID:	18637	18637	18637
4					Plan ID:	18637VT0123456	18637VT0123457	18637VT0123458
5	Review	Review step	Review description and procedure	Step description	Source			
6	Validation 1							
7	1		Compare Metal Levels from the Unified Rate Review (URR) template and Plans & Benefits template.	For all plans, compare the *Metal Level* from the Plans & Benefits template to the *AV Metal Value* from the URR template. The AV values on the URR template and Plans & Benefits template do not have to be identical, but do have to represent the same level of coverage (i.e., metal level				
8	1	a		If *Metal Level* equals "Platinum," verify that the *AV Metal Value* is between 88% and 92%. If standard is not met, mark as not met.	*Metal Level (from Plans & Benefits template)*, *AV Metal Value* (from the URR			
9	1	b		If *Metal Level* equals "Gold," verify that the *AV Metal Value* is between 78% and 82%. If standard is not met, mark as not met.	*Metal Level (from Plans & Benefits template)*, *AV Metal Value* (from the URR	Met	Met	Not Met
10	1	c		If *Metal Level* equals "Silver," verify that *AV Metal Value* is between 68% and 72%. If standard is not met, mark as not met.	*Metal Level (from Plans & Benefits template)*, *AV Metal Value* (from the URR			
11	1	d		If *Metal Level* equals "Bronze," verify that the *AV Metal Value* is between 58% and 62%. If standard is not met, mark as not met.	*Metal Level (from Plans & Benefits template)*, *AV Metal Value* (from the URR			
12	1	e		If *Metal Level* equals "Catastrophic," no AV review is necessary. Mark as met and leave remaining steps blank	*Metal Level (from Plans & Benefits template)*, *AV Metal*			

Read the *Step descriptions* in column D carefully since steps may entail multiple plans under each provider.

To complete *Validation 1*, compare the Plans and Benefits templates data from *Level of Coverage Metal Level* to the *AV Metal Value* in the URR Template.

	A	B	C	D	E	F	G	H	I	J
7	Plan Identifiers									
8	HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPI					Plan Type*	Level of Coverage*
9	30942VT9876543	Fake Plan 1	30942VT987						PPO	Silver
10	30942VT9876544	Fake Plan 2	30942VT987						EPO	Gold
11	30942VT9876545	Fake Plan 3	30942VT987						HMO	Gold

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2



	A	B	C	D	E	F
1				Actuarial Value Review Process Steps		
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan ID:	18637VT0123456
5	Review	Review step	Review description and procedure	Step description	Source	
13				Validation 2		
14	2		Determine whether this plan is identified as a unique plan design.	For all plans, identify from the Plans & Benefits template whether the issuer identified the plan as having a unique plan design.		
15	2	a		If *Unique Plan Design?* = "No," then leave this step blank and go to step 3. If "Yes," then go to 2a.	*Unique Plan Design? (from the Plans & Benefits template)*	
16	2	b		Check supporting documents to determine if there a screenshot of the stand-alone Actuarial Value calculator. If there is a screenshot of the stand-alone Actuarial Value Calculator, proceed to step 2c. If there is not, go to step 4. Leave this step blank.	Supporting documents	
17	2	c		Check the Actuarial Value field of the stand-alone Actuarial Value Calculator to ensure that it is equal to the value in the *Issuer Actuarial Value* field. If not equal, mark as met. If equal, mark as met and proceed to step 4.	*Issuer Actuarial Value*, supporting documents	

Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM

	H	I	J	K	L
7					
8	New/Existing Plan?*	Plan Type*	Level of Coverage*	Unique Plan Design?*	QHP/Non
9	New	PPO	Silver	No	Both
10	New	EPO	Gold	No	Both
11	New	HMO	Gold	No	Both
12	New	PPO	Silver	No	Both
13	New	HMO	Platinum	No	Both
14	New	PPO	Silver	No	Both

Benefits Package 1 | Cost Share Variances 1 | Benefits

To complete *Validation 2a*, use Plans and Benefits Templates *Benefits Package* tab data from *Unique Plan Design?*

To complete *Validation 2c*, use Plans and Benefits Templates *Cost Share Variances* tab data from *Issuer Actuarial Value*

	A	B	C	D	E	F
1				Actuarial Value Review Process Steps		
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan ID:	18637VT0123456
5	Review	Review step	Review description and procedure	Step description	Source	
13				Validation 2		
14	2		Determine whether this plan is identified as a unique plan design.	For all plans, identify from the Plans & Benefits template whether the issuer identified the plan as having a unique plan design.		
15	2	a		If *Unique Plan Design?* = "No," then leave this step blank and go to step 3. If "Yes," then go to 2a.	*Unique Plan Design? (from the Plans & Benefits template)*	
16	2	b		Check supporting documents to determine if there a screenshot of the stand-alone Actuarial Value calculator. If there is a screenshot of the stand-alone Actuarial Value Calculator, proceed to step 2c. If there is not, go to step 4. Leave this step blank.	Supporting documents	
17	2	c		Check the Actuarial Value field of the stand-alone Actuarial Value Calculator to ensure that it is equal to the value in the *Issuer Actuarial Value* field. If not equal, mark as met. If equal, mark as met and proceed to step 4.	*Issuer Actuarial Value*, supporting documents	

Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM

To complete *Validation 2c*, use Plans and Benefits Templates *Cost Share Variances* tab data from *Issuer Actuarial Values*.

	Cost Sharing Reduction Information					
3	HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*
5	30942VT0123456-01		Bronze	Standard Bronze On Exchange Plan		58.00%	Yes
6	30942VT0123456-02		Bronze	Zero Cost Sharing Plan Variation		100.00%	Yes

Cost Share Variances 1 | Benefits Package 2 | Cost Sh

	A	B	C	D	E	F
1			Actuarial Value Review Process Steps			
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan ID:	18637VT0123456
5	Review	Review step	Review description and procedure	Step description	Source	
18			Validation 3			
19	3		Review of *AV Calculator Output Number* to verify whether it is in the correct range for the non-unique benefit design plan.			
20	3	a		If *Metal Level* equals "Platinum," verify that the *AV Calculator Output Number* is between 88% and 92%. If standard is met, proceed to disposition. If standard is not met, mark as not met. If standard is met, mark as met. Leave remaining steps blank.	*Metal Level, AV Calculator Output Number, CSR Variation Type (from the Plans & Benefits template)*	

Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM

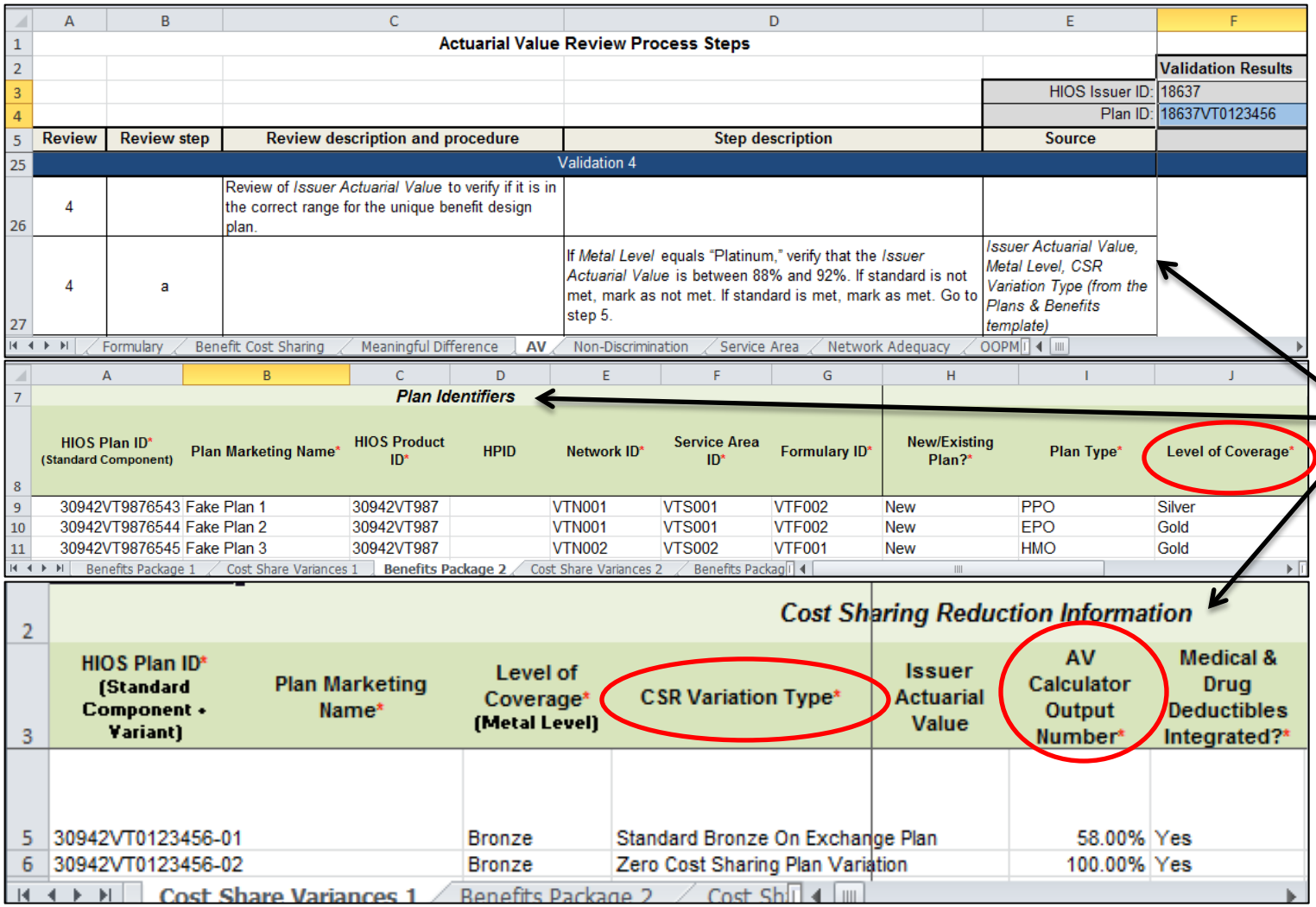
	A	B	C	D	E	F	G	H	I	J
7					*Plan Identifiers*					
8	HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	Network ID*	Service Area ID*	Formulary ID*	New/Existing Plan?*	Plan Type*	Level of Coverage*
9	30942VT9876543	Fake Plan 1	30942VT987		VTN001	VTS001	VTF002	New	PPO	Silver
10	30942VT9876544	Fake Plan 2	30942VT987		VTN001	VTS001	VTF002	New	EPO	Gold
11	30942VT9876545	Fake Plan 3	30942VT987		VTN002	VTS002	VTF001	New	HMO	Gold

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances 2 | Benefits Packag

	A	B	C	D	E	F
2				*Cost Sharing Reduction Information*		
3	HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*
5	30942VT0123456-01		Bronze	Standard Bronze On Exchange Plan		58.00%	Yes
6	30942VT0123456-02		Bronze	Zero Cost Sharing Plan Variation		100.00%	Yes

Cost Share Variances 1 | Benefits Package 2 | Cost Sh

To complete *Validation 3*, use Plans and Benefits Templates *Cost Sharing Variance* tab data from *Level of Coverage Metal Level*, *CSR Variation Type*, and *AV Calculator Output Number*.



	A	B	C	D	E	F
1			Actuarial Value Review Process Steps			
2						Validation Results
3					HIOS Issuer ID:	18637
4					Plan ID:	18637VT0123456
5	Review	Review step	Review description and procedure	Step description	Source	
25	Validation 4					
26	4		Review of *Issuer Actuarial Value* to verify if it is in the correct range for the unique benefit design plan.			
27	4	a		If *Metal Level* equals "Platinum," verify that the *Issuer Actuarial Value* is between 88% and 92%. If standard is not met, mark as not met. If standard is met, mark as met. Go to step 5.	*Issuer Actuarial Value, Metal Level, CSR Variation Type (from the Plans & Benefits template)*	

Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM

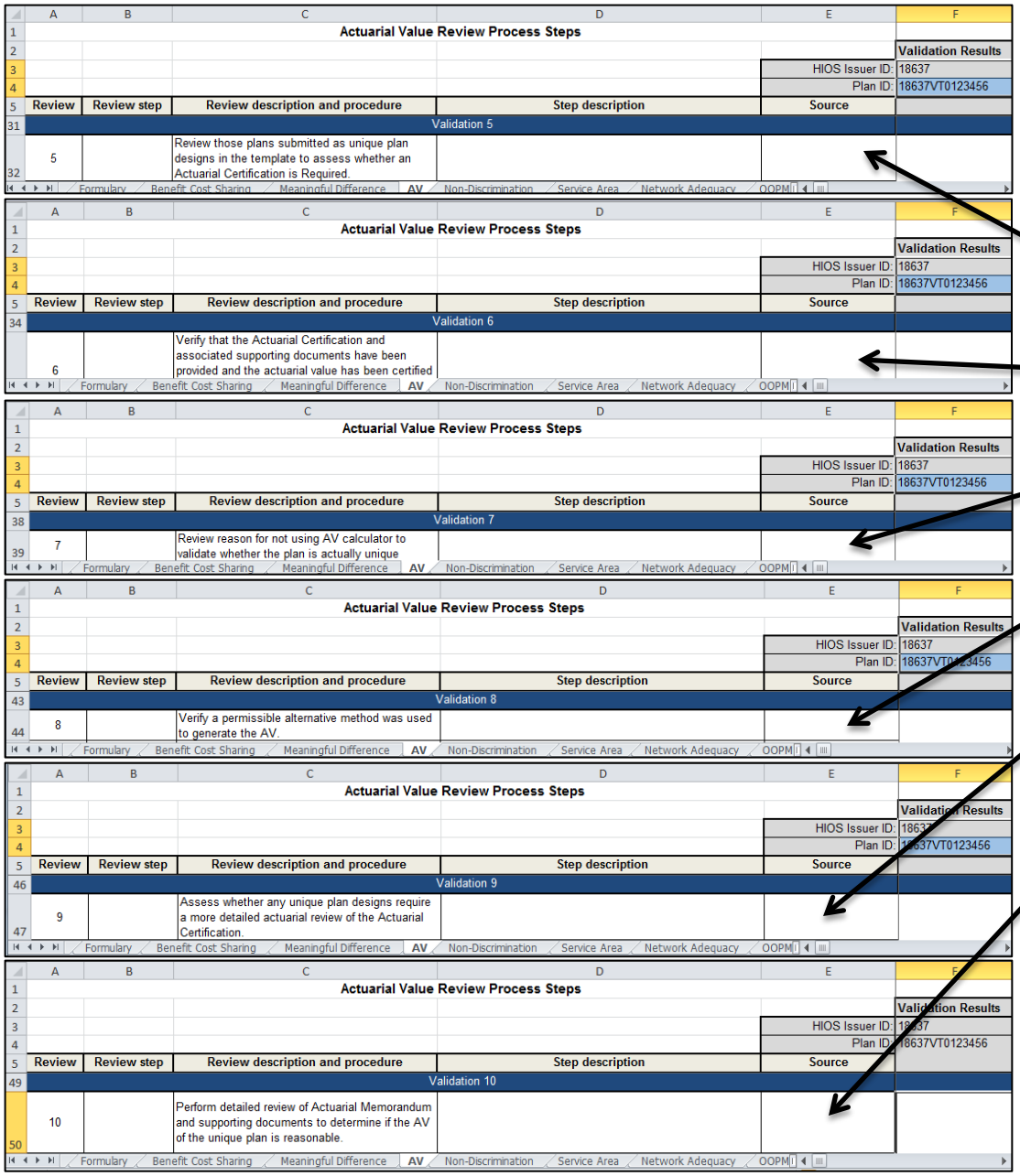
	A	B	C	D	E	F	G	H	I	J
7		Plan Identifiers								
8	HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	Network ID*	Service Area ID*	Formulary ID*	New/Existing Plan?*	Plan Type*	Level of Coverage*
9	30942VT9876543	Fake Plan 1	30942VT987		VTN001	VTS001	VTF002	New	PPO	Silver
10	30942VT9876544	Fake Plan 2	30942VT987		VTN001	VTS001	VTF002	New	EPO	Gold
11	30942VT9876545	Fake Plan 3	30942VT987		VTN002	VTS002	VTF001	New	HMO	Gold

Benefits Package 1 | Cost Share Variances 1 | Benefits Package 2 | Cost Share Variances 2 | Benefits Packag

	A	B	C	D	E	F
2				Cost Sharing Reduction Information		
3	HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*
5	30942VT0123456-01		Bronze	Standard Bronze On Exchange Plan		58.00%	Yes
6	30942VT0123456-02		Bronze	Zero Cost Sharing Plan Variation		100.00%	Yes

Cost Share Variances 1 | Benefits Package 2 | Cost Sh

To complete *Validation 4*, use Plans and Benefits Templates *Cost Sharing Variance* tab data from *Level of Coverage Metal Level*, *CSR Variation Type*, and *AV Calculator Output Number*.



Actuarial Value Review Process Steps

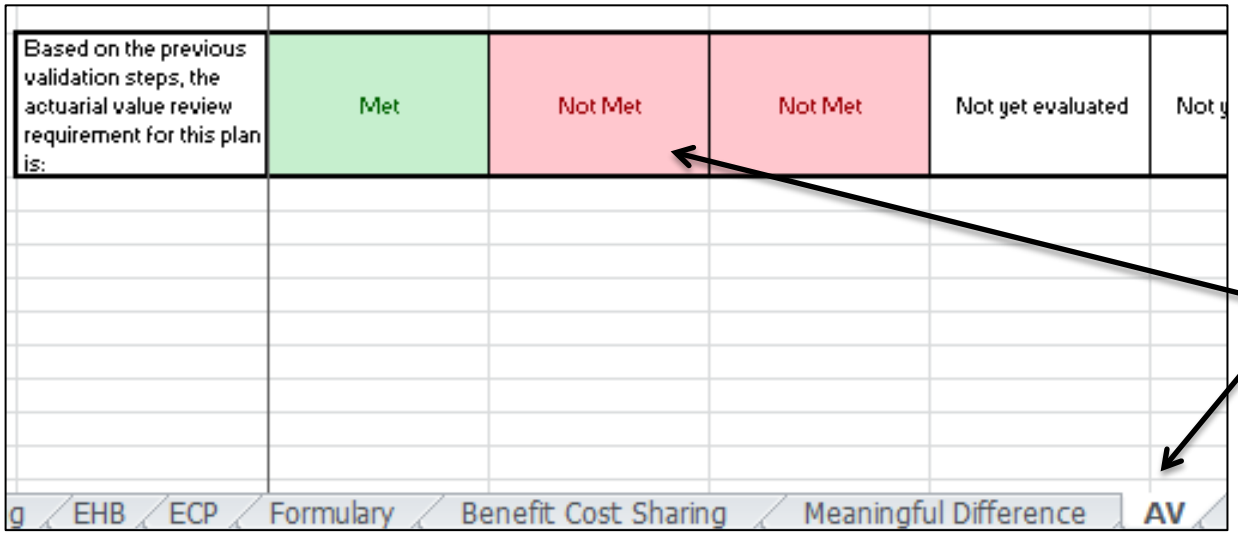
Review	Review step	Review description and procedure	Step description	Source
Validation 5				
5		Review those plans submitted as unique plan designs in the template to assess whether an Actuarial Certification is Required.		
Validation 6				
6		Verify that the Actuarial Certification and associated supporting documents have been provided and the actuarial value has been certified		
Validation 7				
7		Review reason for not using AV calculator to validate whether the plan is actually unique		
Validation 8				
8		Verify a permissible alternative method was used to generate the AV.		
Validation 9				
9		Assess whether any unique plan designs require a more detailed actuarial review of the Actuarial Certification.		
Validation 10				
10		Perform detailed review of Actuarial Memorandum and supporting documents to determine if the AV of the unique plan is reasonable.		

Validation Results
HIOS Issuer ID: 18637
Plan ID: 18637VT0123456

Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | Network Adequacy | OOPM

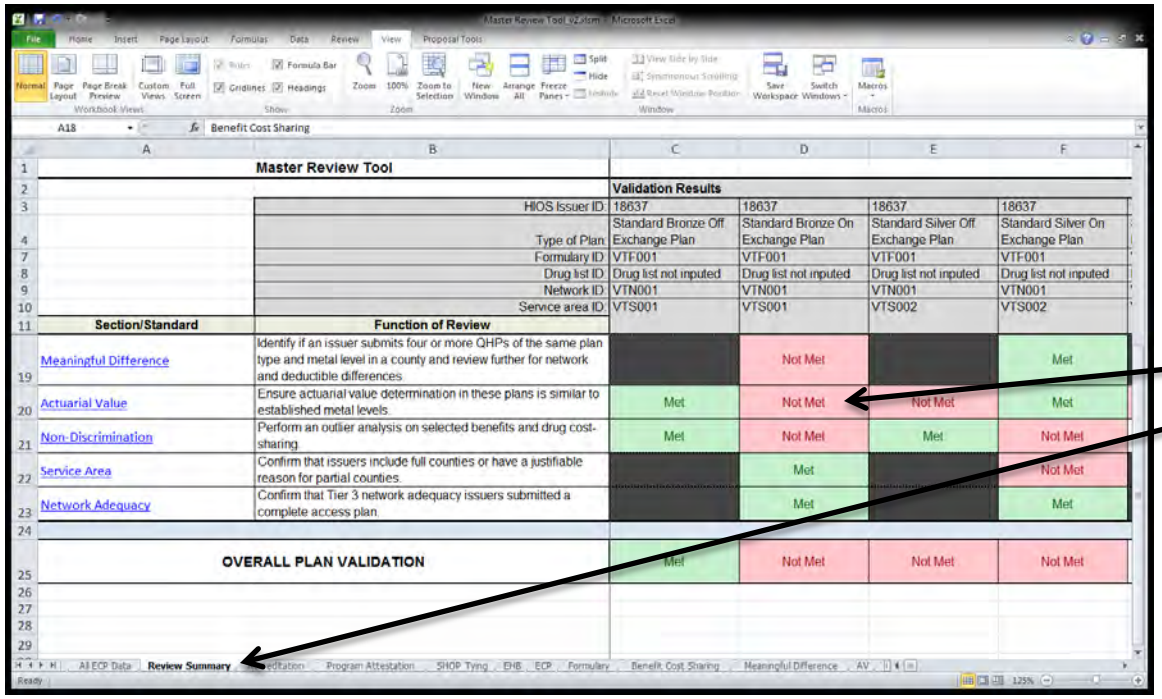
To complete *Validation 5-10*, use Plans and Benefits Templates data from Actuarial Certifications, Actuarial Memorandum, associated supporting documents of unique plan design, and Part 1 URR Template.

2. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *AV* requirements.



The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

3. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *AV* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



	A	B	C	D	E	F
1		**Master Review Tool**				
2			**Validation Results**			
3		HIOS Issuer ID	18637	18637	18637	18637
4		Type of Plan	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
7		Formulary ID	VTF001	VTF001	VTF001	VTF001
8		Drug list ID	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
9		Network ID	VTN001	VTN001	VTN001	VTN001
10		Service area ID	VTS001	VTS001	VTS002	VTS002
11	**Section/Standard**	**Function of Review**				
19	Meaningful Difference	Identify if an issuer submits four or more QHPs of the same plan type and metal level in a county and review further for network and deductible differences.		Not Met		Met
20	Actuarial Value	Ensure actuarial value determination in these plans is similar to established metal levels.	Met	Not Met	Not Met	Met
21	Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
22	Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
23	Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan.		Met		Met
24						
25		**OVERALL PLAN VALIDATION**	Met	Not Met	Not Met	Not Met

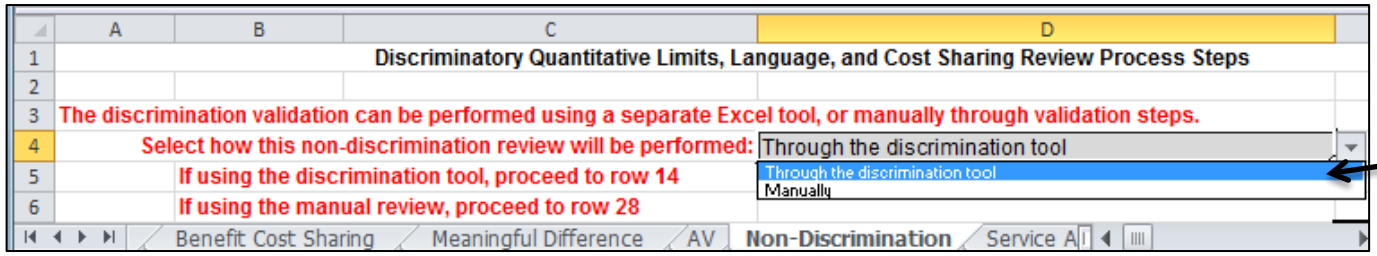
Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

4. Save the Master Review Tool after you have completed the AV review.

XI: NON-DISCRIMINATION BENEFIT REVIEW

The *Non-Discrimination* review conducts plan-level analyses targeting areas where discrimination would most likely occur, consistent with applicable regulations, to ensure that issuers do not employ benefit designs that discourage enrollment of individuals with significant health needs.

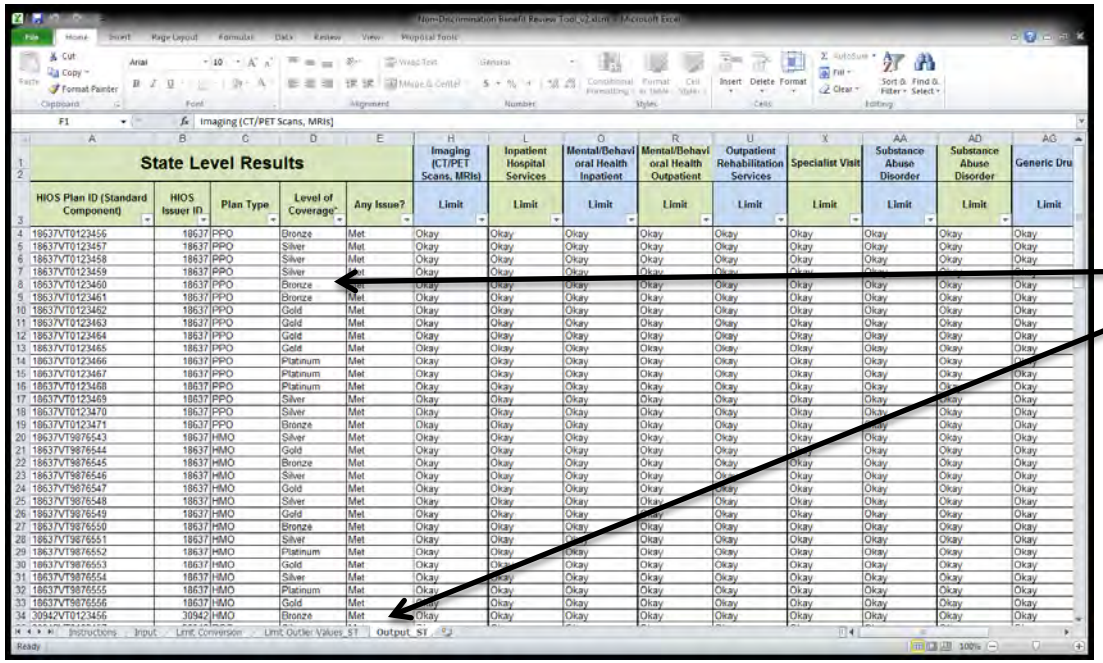
1. Open the Qualified Health Plan Application State Review Tools folder and run the Non-Discrimination Tool for all the plans you wish to evaluate. For more information on running the Non-Discrimination Tool, see section IV. Non-Discrimination Benefit Review Tool in the *QHP Application State Review Tools User Guide: Loading the Data*.
2. If you decide to use the Non-Discrimination Benefit Review stand-alone tool, review the validation steps in the Master Review Tool *Non-Discrimination* tab to better understand the logic behind the Non-Discrimination Benefit Review Tool or to see where you can submit justifications.



Open the Master Review Tool *Non-Discrimination* tab to see the review description.

Use the *drop-down menu* in cell D4 to select how you will perform the review.

3. Open the Non-Discrimination Benefit Review Tool *Output* tab to see the issuer's plans you wish to review.

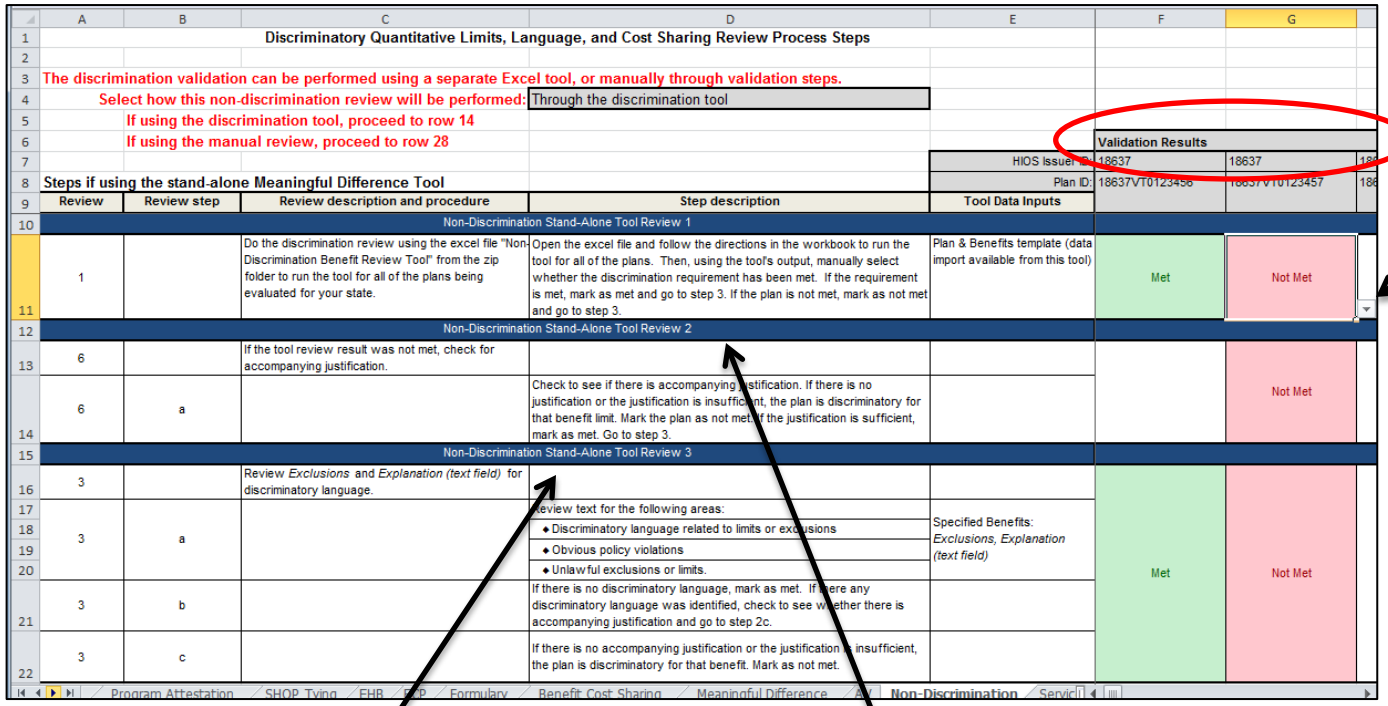


State Level Results

HIOS Plan ID (Standard Component)	HIOS Issuer ID	Plan Type	Level of Coverage	Any Issue?	Imaging (CT/PET Scans, MRIs) Limit	Inpatient Hospital Services Limit	Mental/Behavioral Health Inpatient Limit	Mental/Behavioral Health Outpatient Limit	Outpatient Rehabilitation Services Limit	Specialist Visit Limit	Substance Abuse Disorder Limit	Substance Abuse Disorder Limit	Generic Dru Limit
18637VT0123456	18637	PPO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123457	18637	PPO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123458	18637	PPO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123459	18637	PPO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123460	18637	PPO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123461	18637	PPO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123462	18637	PPO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123463	18637	PPO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123464	18637	PPO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123465	18637	PPO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123466	18637	PPO	Platinum	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123467	18637	PPO	Platinum	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123468	18637	PPO	Platinum	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123469	18637	PPO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123470	18637	PPO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT0123471	18637	PPO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876543	18637	HMO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876544	18637	HMO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876545	18637	HMO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876546	18637	HMO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876547	18637	HMO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876548	18637	HMO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876549	18637	HMO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876550	18637	HMO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876551	18637	HMO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876552	18637	HMO	Platinum	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876553	18637	HMO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876554	18637	HMO	Silver	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876555	18637	HMO	Platinum	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
18637VT9876556	18637	HMO	Gold	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay
30942VT0123456	30942	HMO	Bronze	Met	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay	Okay

Open the Non-Discrimination Benefit Review Tool *Output* tab to see the issuer's plans you wish to evaluate.

4. Using the data in the Non-Discrimination Benefit Review Tool *Output* tab, go to the Master Review Tool *Non-Discrimination* tab and use the drop-down menus in the *Validation Results* columns to indicate if an issuer's plan has met the discrimination requirement.



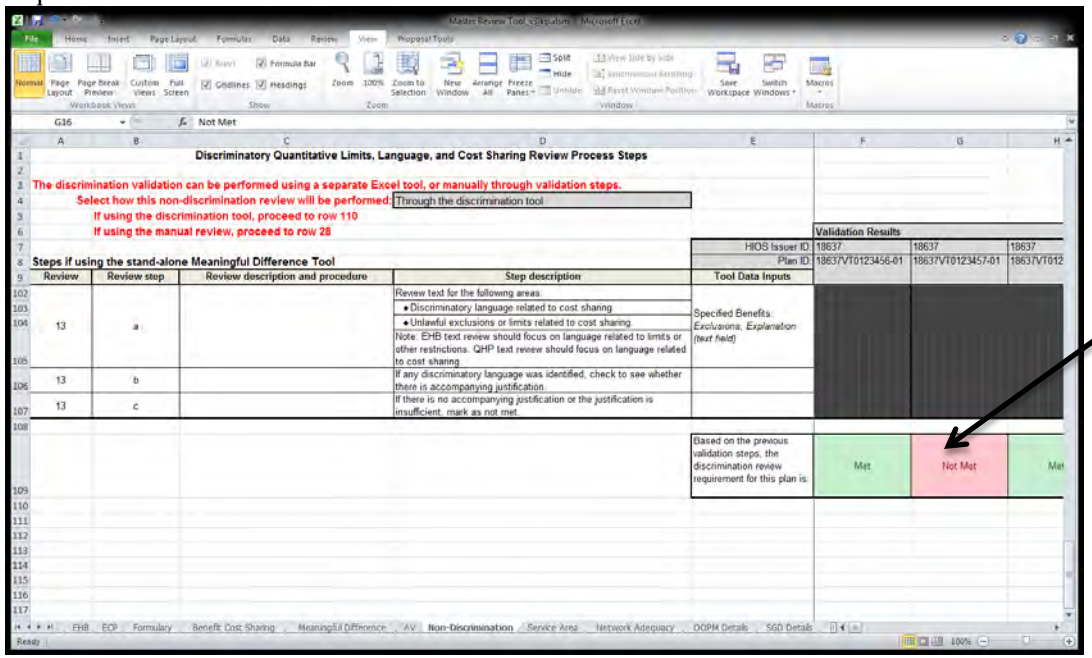
	A	B	C	D	E	F	G
1	Discriminatory Quantitative Limits, Language, and Cost Sharing Review Process Steps						
2							
3	The discrimination validation can be performed using a separate Excel tool, or manually through validation steps.						
4	Select how this non-discrimination review will be performed:			Through the discrimination tool			
5	If using the discrimination tool, proceed to row 14						
6	If using the manual review, proceed to row 28					Validation Results	
7					HIOS Issuer ID:	18637	18637
8	Steps if using the stand-alone Meaningful Difference Tool				Plan ID:	18637VT0123456	18637VT0123457
9	Review	Review step	Review description and procedure	Step description	Tool Data Inputs		
10	Non-Discrimination Stand-Alone Tool Review 1						
11	1		Do the discrimination review using the excel file "Non-Discrimination Benefit Review Tool" from the zip folder to run the tool for all of the plans being evaluated for your state.	Open the excel file and follow the directions in the workbook to run the tool for all of the plans. Then, using the tool's output, manually select whether the discrimination requirement has been met. If the requirement is met, mark as met and go to step 3. If the plan is not met, mark as not met and go to step 3.	Plan & Benefits template (data import available from this tool)	Met	Not Met
12	Non-Discrimination Stand-Alone Tool Review 2						
13	6		If the tool review result was not met, check for accompanying justification.				
14	6	a		Check to see if there is accompanying justification. If there is no justification or the justification is insufficient, the plan is discriminatory for that benefit limit. Mark the plan as not met. If the justification is sufficient, mark as met. Go to step 3.			Not Met
15	Non-Discrimination Stand-Alone Tool Review 3						
16	3		Review *Exclusions* and *Explanation (text field)* for discriminatory language.			Met	Not Met
17	3	a		Review text for the following areas:	Specified Benefits: *Exclusions, Explanation (text field)*		
18				♦ Discriminatory language related to limits or exclusions			
19				♦ Obvious policy violations			
20				♦ Unlawful exclusions or limits.			
21	3	b		If there is no discriminatory language, mark as met. If there any discriminatory language was identified, check to see whether there is accompanying justification and go to step 2c.			
22	3	c		If there is no accompanying justification or the justification is insufficient, the plan is discriminatory for that benefit. Mark as not met.			

Use the *drop-down menus* to indicate **Met** or **Not Met** for each requirement.

If discrimination is **Met**, go to step 3, (Non-Discrimination Stand-Along Tool Review 3), and follow the step descriptions in cells D17-22.

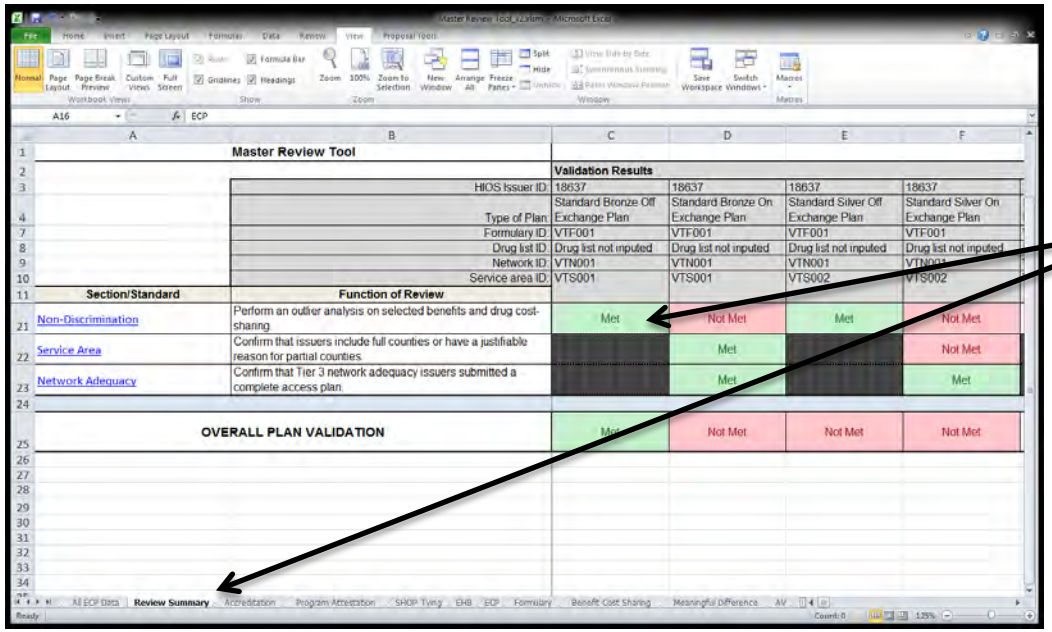
If discrimination is **Not Met**, proceed to step 2, (Non-Discrimination Stand-Alone Tool Review 2), and follow the step descriptions in cell D14 for justification.

5. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Non-Discrimination* requirements.



The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

6. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Non-Discrimination* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool

		Validation Results			
	HIOS Issuer ID	18637	18637	18637	18637
	Type of Plan	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
	Formulary ID	VTF001	VTF001	VTF001	VTF001
	Drug list ID	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
	Network ID	VTN001	VTN001	VTN001	VTN001
	Service area ID	VTS001	VTS001	VTS002	VTS002
Section/Standard	Function of Review				
Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing	Met	Not Met	Met	Not Met
Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties		Met		Not Met
Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan		Met		Met
OVERALL PLAN VALIDATION		Met	Not Met	Not Met	Not Met

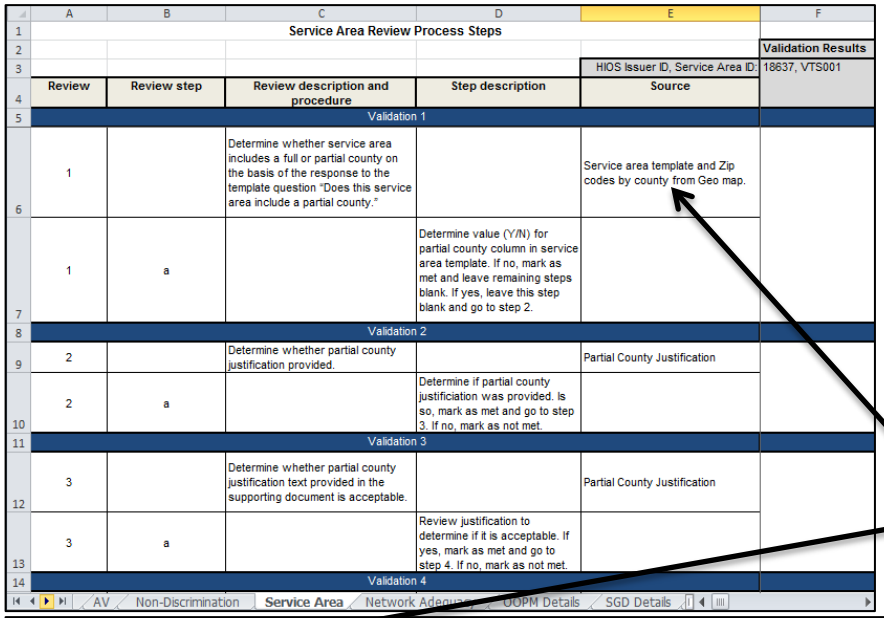
Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

7. Save the Master Review Tool after you have completed the *Non-Discrimination* review.

XII: SERVICE AREA REVIEW

The *Service Area* review verifies that each service area meets geographic standards set forth in the Exchange Final Rule and is non-discriminatory (e.g., service areas of at least an entire county).

1. **Use the Service Area Templates to complete the *Service Area* review.**



	A	B	C	D	E	F
1	Service Area Review Process Steps					
2						Validation Results
3					HIOS Issuer ID, Service Area ID:	18637, VTS001
4	Review	Review step	Review description and procedure	Step description	Source	
5	Validation 1					
6	1		Determine whether service area includes a full or partial county on the basis of the response to the template question "Does this service area include a partial county."		Service area template and Zip codes by county from Geo map.	
7	1	a		Determine value (Y/N) for partial county column in service area template. If no, mark as met and leave remaining steps blank. If yes, leave this step blank and go to step 2.		
8	Validation 2					
9	2		Determine whether partial county justification provided.		Partial County Justification	
10	2	a		Determine if partial county justificiation was provided. Is so, mark as met and go to step 3. If no, mark as not met.		
11	Validation 3					
12	3		Determine whether partial county justification text provided in the supporting document is acceptable.		Partial County Justification	
13	3	a		Review justification to determine if it is acceptable. If yes, mark as met and go to step 4. If no, mark as not met.		
14	Validation 4					

AV | Non-Discrimination | Service Area | Network Adequacy | OOPM Details | SGD Details

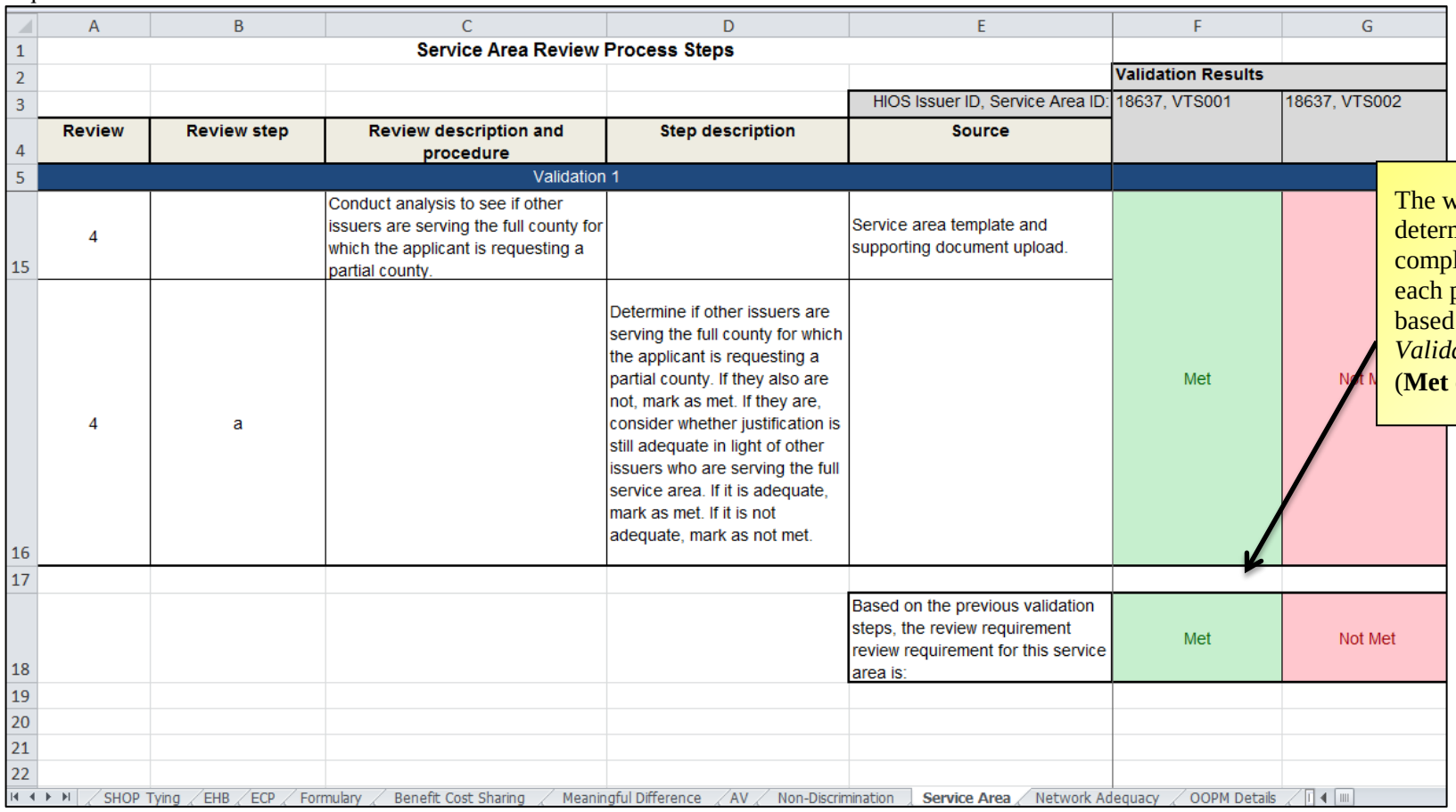
Read the *Step descriptions* in column D carefully since steps may entail multiple plans under each provider and a comparison of Service Area templates.

To complete *Validation 1-4*, use Service Area Templates data from *Partial County* for *HIOS Issuer ID you are* validating.

	A	B	C	D	E
1	**Service Area v2.91**	*All fields with an asterisk (*) are required*			
2	Validate	*To validate, press the Validate button or Ctrl + Shift + V. To finalize, press the Finalize button or Ctrl + Shift + F*			
3		*Click Create Service Area IDs button (or Ctrl + Shift + S) to create service area ids based on your state*			
4	Finalize	*Service Area IDs will populate in the drop-down box in Service Area ID column*			
5		*For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)*			
6	**HIOS Issuer ID:***	18637			
7	**Issuer State:***	VT			
8					
9	Create Service Area IDs				
10					
11	**Service Area ID***	**Service Area Name***	**State***	**County Name**	**Partial County**
12	**Required:** Enter the Service Area ID	**Required:** Enter the Service Area Name	**Required:** Does this Service Area cover the entire state?	**Required if State is "No":** Select the County - FIPS this Service Area covers	**Required if State is "No":** Does this Service Area include a partial county?
13	VTS001	Fake Service Area 1	Yes		
14	VTS002	Fake Service Area 2	No	Addison - 50001	No
15	VTS002	Fake Service Area 2	No	Bennington - 50003	No

Service Areas

2. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Service Area* requirements.

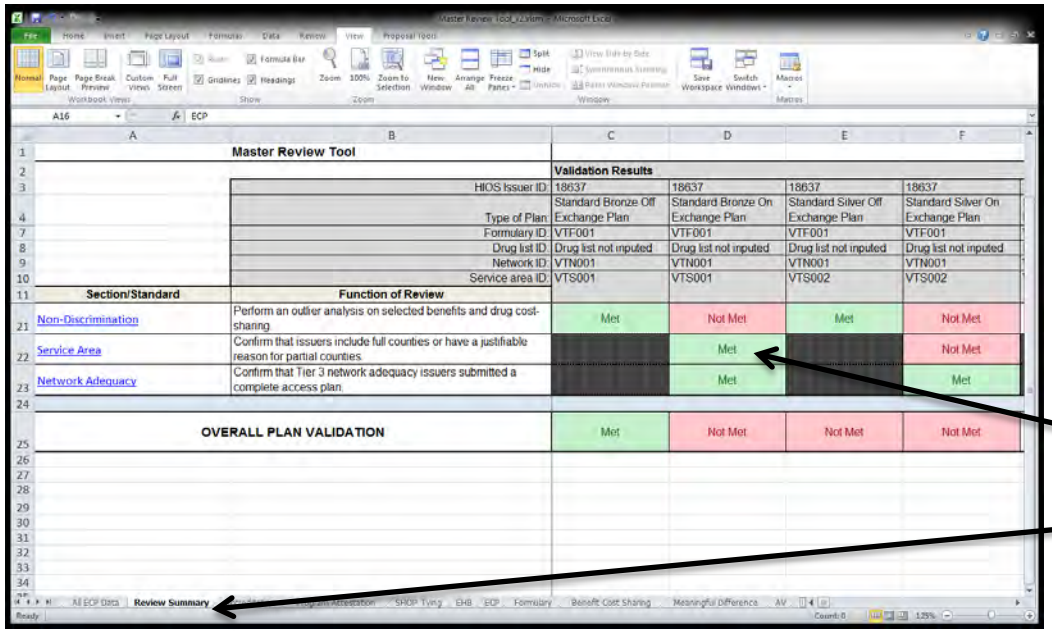


	A	B	C	D	E	F	G
1	Service Area Review Process Steps						
2						Validation Results	
3					HIOS Issuer ID, Service Area ID:	18637, VTS001	18637, VTS002
4	**Review**	**Review step**	**Review description and procedure**	**Step description**	**Source**		
5	Validation 1						
15	4		Conduct analysis to see if other issuers are serving the full county for which the applicant is requesting a partial county.		Service area template and supporting document upload.		
16	4	a		Determine if other issuers are serving the full county for which the applicant is requesting a partial county. If they also are not, mark as met. If they are, consider whether justification is still adequate in light of other issuers who are serving the full service area. If it is adequate, mark as met. If it is not adequate, mark as not met.		Met	Not M
17							
18					Based on the previous validation steps, the review requirement review requirement for this service area is:	Met	Not Met
19							
20							
21							
22							

SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | **Service Area** | Network Adequacy | OOPM Details

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

3. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Service Area* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



	A	B	C	D	E	F
1	Master Review Tool					
2			Validation Results			
3		HIOS Issuer ID:	18637	18637	18637	18637
4		Type of Plan:	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
7		Formulary ID:	VTF001	VTF001	VTF001	VTF001
8		Drug list ID:	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
9		Network ID:	VTN001	VTN001	VTN001	VTN001
10		Service area ID:	VTS001	VTS001	VTS002	VTS002
11	Section/Standard	Function of Review				
21	Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
22	Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
23	Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan.		Met		Met
24						
25	OVERALL PLAN VALIDATION		Met	Not Met	Not Met	Not Met

Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

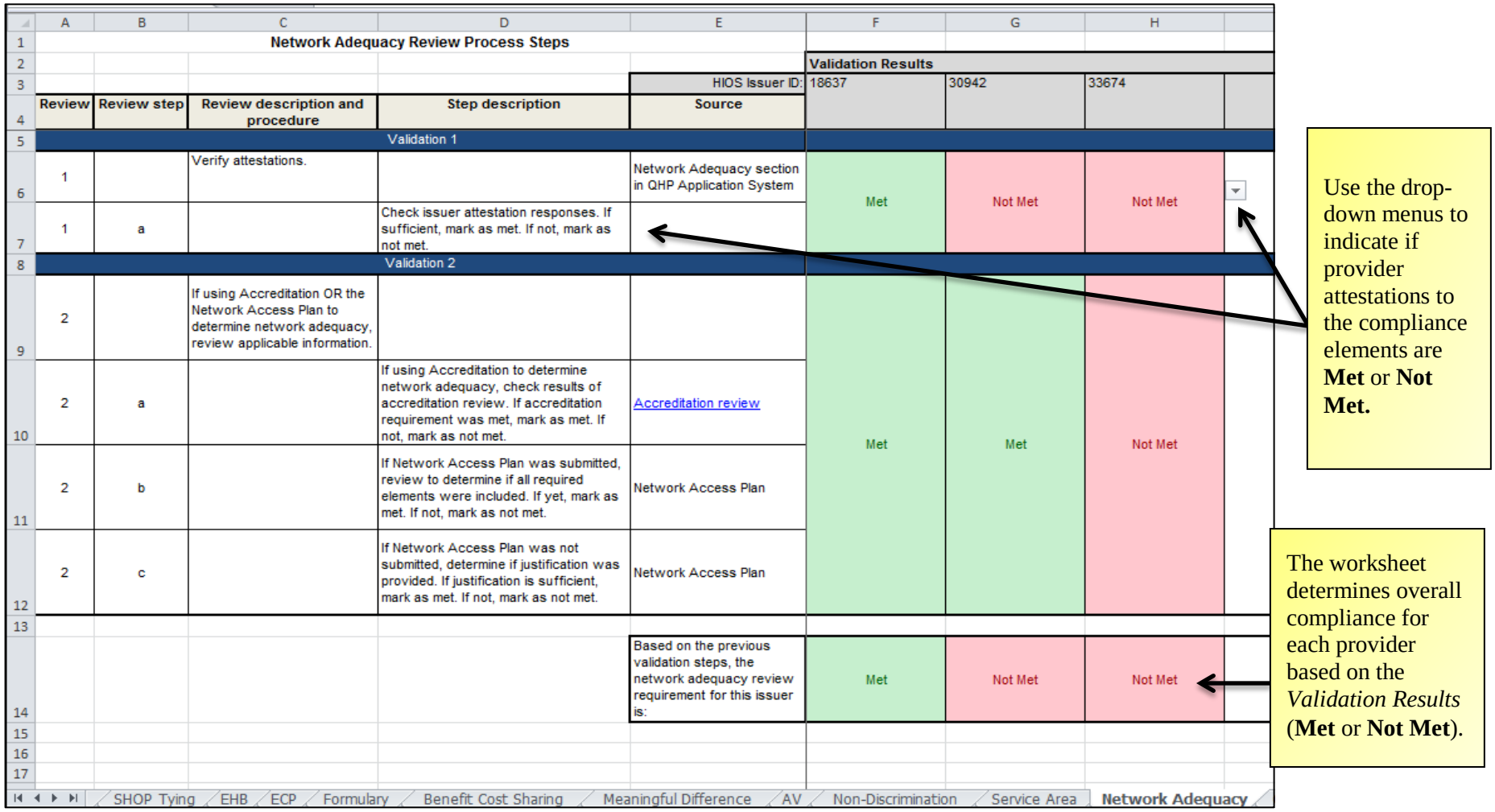
4. Save the Master Review Tool after you have completed the *Service Area* review.

XIII. NETWORK ADEQUACY REVIEW

The *Network Adequacy* review includes different processes for evaluating network adequacy including compliance with a current or proposed state network adequacy review, accepting attestations from accredited issuers, or requiring issuers to submit a network adequacy plan.

1. **Use the Network Adequacy section in QHP Application and Network Access Plan to complete the *Network Adequacy* review.**

2. Use the drop-down menus to indicate if provider attestations to the compliance elements are **Met** or **Not Met.**



	A	B	C	D	E	F	G	H
1	Network Adequacy Review Process Steps							
2						Validation Results		
3					HIOS Issuer ID:	18637	30942	33674
4	Review	Review step	Review description and procedure	Step description	Source			
5	Validation 1							
6	1		Verify attestations.		Network Adequacy section in QHP Application System	Met	Not Met	Not Met
7	1	a		Check issuer attestation responses. If sufficient, mark as met. If not, mark as not met.				
8	Validation 2							
9	2		If using Accreditation OR the Network Access Plan to determine network adequacy, review applicable information.			Met	Met	Not Met
10	2	a		If using Accreditation to determine network adequacy, check results of accreditation review. If accreditation requirement was met, mark as met. If not, mark as not met.	Accreditation review			
11	2	b		If Network Access Plan was submitted, review to determine if all required elements were included. If yet, mark as met. If not, mark as not met.	Network Access Plan			
12	2	c		If Network Access Plan was not submitted, determine if justification was provided. If justification is sufficient, mark as met. If not, mark as not met.	Network Access Plan			
13								
14					Based on the previous validation steps, the network adequacy review requirement for this issuer is:	Met	Not Met	Not Met
15								
16								
17								

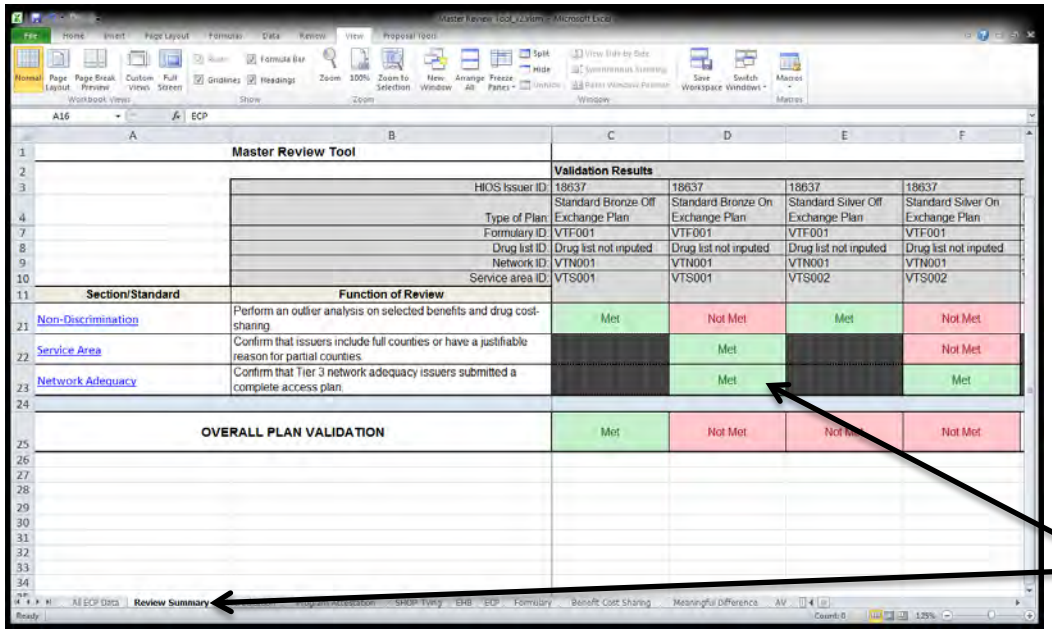
SHOP Tying | EHB | ECP | Formulary | Benefit Cost Sharing | Meaningful Difference | AV | Non-Discrimination | Service Area | **Network Adequacy**

Use the drop-down menus to indicate if provider attestations to the compliance elements are **Met** or **Not Met.**

The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**).

3. The worksheet determines overall compliance for each provider based on the *Validation Results* (**Met** or **Not Met**) for the *Network Adequacy* requirements.

4. After you have manually populated **Met** or **Not Met** for each issuer's plan in the Master Review Tool *Network Adequacy* tab, open the Master Review Tool *Review Summary* tab to see the auto-populated results.



Master Review Tool

		Validation Results			
	HIOS Issuer ID	18637	18637	18637	18637
	Type of Plan	Standard Bronze Off Exchange Plan	Standard Bronze On Exchange Plan	Standard Silver Off Exchange Plan	Standard Silver On Exchange Plan
	Formulary ID	VTF001	VTF001	VTF001	VTF001
	Drug list ID	Drug list not inputed	Drug list not inputed	Drug list not inputed	Drug list not inputed
	Network ID	VTN001	VTN001	VTN001	VTN001
	Service area ID	VTS001	VTS001	VTS002	VTS002
Section/Standard	Function of Review				
Non-Discrimination	Perform an outlier analysis on selected benefits and drug cost-sharing.	Met	Not Met	Met	Not Met
Service Area	Confirm that issuers include full counties or have a justifiable reason for partial counties.		Met		Not Met
Network Adequacy	Confirm that Tier 3 network adequacy issuers submitted a complete access plan.		Met		Met
OVERALL PLAN VALIDATION		Met	Not Met	Not Met	Not Met

Open the Master Review Tool *Review Summary* tab to see the auto-populated review results.

5. Save the Master Review Tool after you have completed the *Network Adequacy* review.

APPENDIX I: ACRONYMS AND TERMS

Acronym	Definition
AV	Actuarial Value
AVC	Actuarial Value Calculator
APTC	Advance Payment of the Premium Tax Credit
ACA	Affordable Care Act
API	Application Programming Interface
BPCK	Branded Pack
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
COA	Certificate of Authority
CALT	Collaborative Application Lifecycle Tool
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CSR	Cost-Sharing Reduction
HHS	Department of Health and Human Services
DOI	Department of Insurance
DSH	Disproportionate Share Hospital
EIN	Employer Identification Number
ECP	Essential Community Provider
EHB	Essential Health Benefit
EPO	Exclusive Provider Organization
FEIN	Federal Employer Identification Number
FPL	Federal Poverty Level Version 1 B-2
FQHC	Federally Qualified Health Center
FFM	Federally-Facilitated Marketplace
FF-SHOP	Federally-Facilitated Small Business Health Options Program
GSA	General Services Administration
GPCK	Generic Pack
HIOS	Health Insurance Oversight System
HIPAA	Health Insurance Portability and Accountability Act

Acronym	Definition
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRA	Health Reimbursement Arrangement
HSA	Health Savings Account
ISS	Interactive Survey System
MCO	Managed Care Organization
MOOP, also OOPM	Maximum Out of Pocket, also OOPM
M	Multiplier
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NPI	National Provider Identifier
OIG	Office of the Inspector General
OOPM, also MOOP	Out-Of-Pocket Maximum, also MOOP
POS	Point of Service
PPO	Preferred Provider Organization
QHP	Qualified Health Plan
SBD	Semantic Branded Drug
SCD	Semantic Clinical Drug Version 1 B-3
SHOP	Small Business Health Options Program
SGD	Small Group Deductible
SEP	Special Enrollment Period
SBM	State Based Marketplace
SERVIS	State Exchange Resource Virtual Information System
SPM	State Partnership Marketplaces
SBC	Summary of Benefits and Coverage
SERFF	System for Electronic Rate and Form Filing
TIN	Taxpayer Identification Number
TTY	Term Types
UMLS	Unified Medical Language System
UCAA	Uniform Certificate of Authority Application

Acronym	Definition
USP	United States Pharmacopeia
.xlms	Excel Macro-Enabled Workbook