State QHP Application Review Tools: Optional Refinements to Non-Discrimination, Meaningful Difference, and Cost-Sharing Reduction Plan Variation Reviews

The Centers for Medicare and Medicaid Services (CMS) recently completed its initial review of Qualified Health Plan (QHP) applications for certification in the Federally Facilitated Marketplace (FFM). CMS utilized the automated review tools – which are also available to States - to review issuers' applications in FFM states for QHP Non-Discrimination, Meaningful Difference, Cost-Sharing Reduction (CSR) plan variations, and Essential Community Providers. During this year's QHP review, several minor refinements were made to the processes and review methodology as outlined by the automated tools and the Master Review Tool for non-discrimination, meaningful difference, and CSR Plan Variations. This document explains those refinements.

Using the state QHP application review tools is not a requirement, nor is using this guide explaining the refinements CMS made during its review. A State Partnership Marketplace or State Based Marketplace may wish to adopt some or all of these refinements, and guidance on how to implement is provided below.

Lastly, CMS developed the *Benefit Correction Notice Resource Guide for Issuers*[1] to better assist issuers in FFM states in addressing corrections request by CMS related to non-discrimination, meaningful difference, and cost-sharing reduction plan variations. States may find the *Resource Guide* helpful in their own reviews and in guidance to issuers.

Refinements to Meaningful Difference Review

CMS made two refinements to the FFM QHP Meaningful Difference review that were in addition to the steps outlined in the Master Review Tool. First, two additional dimensions by which plans could be meaningfully different were added to the review. The two dimensions are whether a plan is Health Savings Account (HSA) eligible and whether a plan offers child-only or adult-only coverage.

Because the original Meaningful Difference Tool analysis does not account for these dimensions, two data fields—*HSA Eligible* and *Child-Only Offering*—were

[1] The Benefit Correction Notice Resource Guide for Issuers can be found on RegTap at https://www.regtap.info/ or https://www.regtap.info/uploads/library/Benefit_Correction_Notice_Resource_Guide_for_Issuers_5CR_062613.pdf

manually reviewed. These data elements are located on the Benefits Package tab of the Plans & Benefits template. A difference between plans in either of these benefit fields was considered meaningfully different.

If a state would like to include *HSA Eligible* and *Child-Only Offering* in their Meaningful Difference analysis, CMS recommends the following:

1. Run the standalone Meaningful Difference Tool as it would normally be used.

2. Open the corresponding Plans & Benefits templates for any plans that have a "Not Met" on the Summary tab of the Meaningful Difference tool.

3. Compare the plans that have a "Not Met" for differences in covered benefits as described in the Master Review Tool.

4. For those plans still considered as not meaningfully different, compare the *HSA Eligible* and *Child-Only Offering* data fields for these plans on the Plans & Benefits template. If a difference is found in either data field between the plans, manually change the plans' statuses to "Met" in the Master Review Tool.

The second refinement to the Meaningful Difference review assessed the number of available plan options per county to ensure that consumers had an adequate number of plan options across all metal levels of coverage. A plan offered in counties with only a few plan options was removed from the Meaningful Difference review. For these particular plans, CMS believes that an issuer was not pursuing a strategy to monopolize virtual "shelf space." CMS evaluated the number of plan options in each of the four metal levels (Bronze, Silver, Gold, and Platinum) in a county; limited number of plan options in one or more of the metal levels exempted that county from the Meaningful Difference review. Individual and Small Business Health Options Program (SHOP) markets were considered separately, and limited plan options in one or both markets also exempted the county from the review. States have the discretion to determine what is considered a limited number of plan options.

If a state would like to incorporate this refinement in its Meaningful Difference review, CMS recommends the following:

1. Run the standalone Meaningful Difference Tool as it would normally be used.

2. Manually determine the number of plan options available in each county broken out by metal levels (Bronze, Silver, Gold, and Platinum) and by market type (Individual or SHOP).

3. Determine the minimum number of plans that a county must have for each metal level in each market type.

4. Identify every county that does not meet this minimum number of plans. The minimum number determination is up to the state's discretion.

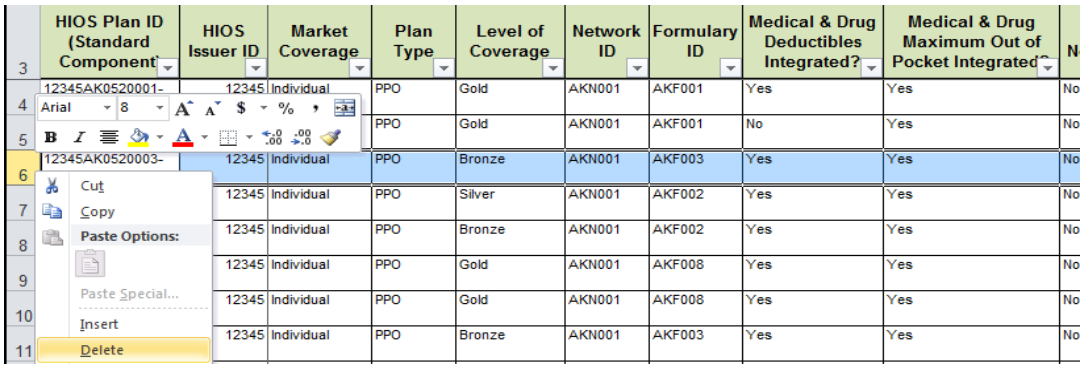
5. Identify every plan that is offered in these counties.

6. Go to the Plan Info Input tab of the Meaningful Difference Tool.

7. Find every plan that was identified in Step 5 and delete it entirely from the Plan Info Input tab.

    a. Ensure that you delete the entire row that the plan is contained in; do not simply press the delete button on your keyboard. **There cannot be any gaps, spaces or blanks in the data on the Plan Info Input tab or a tool error will occur.** See Figure 1.

Figure 1. Deleting a plan from the Meaningful Difference Tool



8. Continue with Step 4 of the Instructions tab for the Meaningful Difference Tool and run the rest of the standalone Meaningful Difference Tool, as it would normally be used. **Be sure not to reimport plan data or it will add back in the plans you just deleted.**

9. The results on the Summary tab will now exclude any plans that are offered in counties with a limited number of plan options, which were previously deleted in Step 7 of this refinement.

10. To maintain a complete and updated account of all plans, manually enter "Met" for the Meaningful Difference review for the plans that were deleted as part of the refinement process in the Master Review Tool.

Refinements to Non-Discrimination Review

For the Non-Discrimination QHP Benefit review, CMS adjusted the calculated cost-sharing outlier thresholds in two ways. The first adjustment changed all bronze level copayment thresholds that were equal to "$0" to "No Result." A bronze level threshold equal to $0 would imprecisely trigger a "Not Met" notice to any issuer with a bronze plan with a copayment value greater than $0. While CMS applied this adjustment to both national and state-specific outlier thresholds for FFM states, states could make this adjustment for their state thresholds.

The second adjustment targeted cost sharing thresholds for higher value metal levels if they were greater than the thresholds of a lower value metal level. CMS decreased these cost sharing thresholds so that they were equal to or less than the thresholds of a lower value metal level. For instance, if a given benefit had a silver copayment threshold of $500 and the gold copayment threshold is $600, the gold copayment thresholds was reduced to $500.

This second adjustment was made because CMS expected that the cost sharing outliers would be the same or decrease when moving from bronze to platinum plans for a given benefit. In some cases, this pattern did not occur due to sample sizes producing some variability in the data.

If a state would like to incorporate the Non-Discrimination QHP Benefit refinement in its own reviews, CMS recommends the following:

1. Run the standalone Non-Discrimination Tool, version 2.1 or higher, as it would normally be used.

2. Go to the CS Outlier Values_ST tab.

3. Change all "$0" copayment data fields in the Bronze column to "No Result." **Note that the value must say "No Result" or it will cause an error.** See figure 2 and figure 3 below.

4. Examine Silver, Gold and Platinum thresholds to identify higher-metal level thresholds that are higher than the lower-value metal level threshold for the same benefit. Set the higher-value metal level threshold equal to the lower-value metal level threshold. See figure 2 and figure 3.

5. Go to the Instructions tab of the Non-Discrimination Tool.

6. Select "No" for Step 6 "Would you like to calculate the state outlier thresholds" in the Non-discrimination Tool instructions tab. **Use version 2.1 or higher of the Non-Discrimination Benefit Review Tool or an error may occur.**

7. Rerun the standalone Non-Discrimination Benefit Review Tool.

8. The calculated outliers and "Not Mets" in the output tabs should now reflect the outlier threshold refinements.

Figure 2. Example of Selected Cost-Sharing Outlier Thresholds before Refinement[2] (Illustrative Only)

State Level Cost Sharing Outlier Thresholds					
Benefit	Benefit Field	Outlier Threshold Value			
		Bronze	Silver	Gold	Platinum
Mental/Behavioral Health Inpatient Services	Copayment	$2,400.00	$2,700.00	$1,800.00	$1,900.00
	Coinsurance	70.00%	45.00%	35.00%	35.00%
Mental/Behavioral Health Outpatient Services	Copayment	$0.00	$187.50	$125.00	$42.50
	Coinsurance	75.00%	75.00%	80.00%	50.00%

Figure 3. Example of Selected Cost-Sharing Outlier Thresholds after Refinement (changes are highlighted in yellow)

State Level Cost Sharing Outlier Thresholds					
Benefit	Benefit Field	Outlier Threshold Value			
		Bronze	Silver	Gold	Platinum
Mental/Behavioral Health Inpatient Services	Copayment	$2,400.00	$2,400.00	$1,800.00	$1,800.00
	Coinsurance	70.00%	45.00%	35.00%	35.00%
Mental/Behavioral Health Outpatient Services	Copayment	No Result	$187.50	$125.00	$42.50
	Coinsurance	75.00%	75.00%	75.00%	50.00%

Justifications

We suggest that state reviewers communicate with issuers that have received "Not Mets" and ask them to modify their data values or to submit appropriate justifications. States may refer to or use optional CMS justification documents, which may be found at http://www.serff.com/plan_management_instructions.htm. State reviewers have the discretion to define the standards of "appropriate justification."

[2] Note that this data is for illustration purposes only and are not based on any submitted QHP applications.

Refinements to Cost-Sharing Reduction (CSR) Plan Variation Review

Federal regulation under 45 CFR 156.420(e) states that when a QHP issuer designs its CSR plan variations, it must ensure that the cost sharing required of enrollees under any silver plan variation of a standard silver plan for an essential health benefit from a provider (including a provider outside the plan's network) does not exceed the corresponding cost sharing required in the standard silver plan or any other silver plan variation thereof with a lower actuarial value (AV). In order to meet the required AV, a QHP issuer may decrease the coinsurance or copay for a particular benefit, or make the benefit exempt from the deductible.

The automated cost sharing review tool compares the cost sharing for the standard plan and each silver plan variation thereof, and determines whether EHB cost sharing decreases, or stays the same, as the AV of the silver plan variations increases. This process is described in the Master Review Tool under CSR Review Validation 6. The two tables below illustrate which data entry values from the Plan and Benefits template comply with the federal regulation and those that we believe may be in conflict with the regulation. For example, if an issuer entered "no charge" for a particular benefit for its standard silver plan, but then entered "no charge after deductible" for the same benefit for one of its silver plan variations, that silver plan variation would not comply with the regulation. This is because the lower income individual in the silver plan variation would be required to meet the deductible before the "no charge" coinsurance rate was applied, while an individual in the standard plan would not be required to meet the deductible.

Figure 4. Coinsurance Data Entry Options in the Plans and Benefits Template

Standard Silver Plan Coinsurance Values	Silver Plan Variation Coinsurance Values That Comply with the Regulation	Silver Plan Variation Coinsurance Values That May be in Conflict with the Regulation
No Charge	• No Charge • 0% Coinsurance	• No Charge After Deductible • Coinsurance > 0 • Coinsurance After Deductible (any value)
No Charge After Deductible	• No Charge After Deductible • No Charge • 0% Coinsurance	• Coinsurance > 0 • Coinsurance After Deductible > 0

	• 0% Coinsurance After Deductible	
X% Coinsurance	• No Charge • Coinsurance ≤ the value in the standard plan or plan variation with lower AV	• No Charge After Deductible • Coinsurance > the standard plan or plan variation with lower AV • Coinsurance After Deductible (any value)
X% Coinsurance After Deductible	• No Charge • No Charge After Deductible • Coinsurance ≤ the standard plan or plan variation with lower AV • Coinsurance After Deductible ≤ the standard plan or plan variation with lower AV	• Coinsurance > the standard plan or plan variation with lower AV • Coinsurance After Deductible > the standard plan or plan variation with lower AV

Figure 5. Copay Data Entry Options in the Plans and Benefits Template

Standard Silver Plan Copay Values	Silver Plan Variation Copay Values That Comply with the Regulation	Silver Plan Variation Copay Values That May be in Conflict with the Regulation
No Charge	• No Charge • $0 Copay	• No Charge After Deductible • Copay > 0 • Copay After Deductible (any value) • Copay Before Deductible (any value)
No Charge After Deductible	• No Charge After Deductible • No Charge • $0 Copay • $0 Copay After Deductible	• Copay > 0 • Copay After Deductible > 0 • Copay Before Deductible (any value)
$X Copay	• No Charge • Copay ≤ the standard	• No Charge After Deductible

	plan or plan variation with lower AV • Copay Before Deductible ≤ the standard plan or plan variation with lower AV	• Copay > the standard plan or plan variation with lower AV • Copay After Deductible (any value) • Copay Before Deductible > the standard plan or plan variation with lower AV
$X Copay After Deductible	• No Charge • No Charge After Deductible • Copay ≤ the standard plan or plan variation with lower AV • Copay After Deductible ≤ the standard plan or plan variation with lower AV	• Copay > the standard plan or plan variation with lower AV • Copay After Deductible > the standard plan or plan variation with lower AV • Copay Before Deductible (any value)
$X Copay Before Deductible	• Copay Before Deductible ≤ the standard plan or plan variation with lower AV • No Charge • $0 Copay	• No Charge After Deductible • Copay > 0 • Copay After Deductible (any value) • Copay Before Deductible > the standard plan or plan variation with lower AV

The automated cost sharing review tool does not fully account for all of the possible acceptable scenarios listed in the tables above. If the cost sharing structure is different between the standard plan and one of the related silver plan variations, the automated tool flags that change as a potential area for further review and indicates "Not Met" for the plan. For example, an issuer may have a standard silver plan with a coinsurance of "20% Coinsurance After Deductible." If any of the related silver plan variations have a cost sharing structure other than "X% coinsurance after deductible" or "No Charge After Deductible" then the tool indicates that this plan is "Not Met" for the review. The tool will also indicate "Not Met" if the coinsurance after deductible is greater than 20%.

As a result, CMS may manually change the review from "Not Met" to "Met" in accordance with the above tables. For example:

- The tool will indicate "Not Met" if the issuer had "X% Coinsurance After Deductible" for the standard plan and had either "No Charge" or "0%" for one of the silver plan variations. In this situation, the cost sharing decreases as the AV increases, and will change the review from "Not Met" to "Met".

- The tool will indicate "Not Met" if the issuer had "X% Coinsurance After Deductible" for the standard plan and had "X% Coinsurance" with a positive value for one of the silver plan variations (such that the benefit is not subject to the deductible). For example, the issuer may have input "20% Coinsurance After Deductible" for the standard plan and 20% (or less) coinsurance for the silver plan variations. This type of change does not violate federal regulations since in this example, the consumer would be responsible for the full deductible plus the 20% coinsurance for the standard plan, but would only pay the coinsurance under the silver plan variation. As a result, CMS will manually change the review from "Not Met" to "Met." We note that the deductible could not be expanded to cover additional benefits, as this would increase the consumer's cost sharing obligation.

- The tool works similarly with copays, and will indicate "Not Met" if the issuer had "$X copay After Deductible" for the 73% AV plan variation, for example, and "$Y" for the 87% AV plan variation. In this case, if the "$Y" copay is less than or equal to the $X copay after deductible for the 73% AV plan variation, the cost sharing decreases as the AV increases and the review may be changed to "Met."

There are still situations where changes in cost sharing structure make it difficult to assess compliance and CMS will view the plan as "Not Met" when using the tool for FFM states. For example, the tool will produce a result of "Not Met" if the standard plan has 20% coinsurance and one of the silver plan variations has "No Charge After Deductible." In this case, the cost sharing does not necessarily decrease as the AV increases, leading to a potential conflict with the regulation.

Additional Questions

If you have any questions or concerns about these refinements, please contact us at QHPInfo_States@cms.hhs.gov.