

# Washington State SERFF Health and Disability Binder Filing General Instructions

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## Instructions

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### I. SERFF Binder Requirements for All Filers

- A. Plan Year 2024 Binders must be submitted in SERFF by May 18, 2023.
  - 1. Qualified Health Plans (QHPs): Issuers must file a binder containing all QHP data necessary for products offered inside, outside, or both inside and outside the Health Benefit Exchange ("Exchange"). See the QHP Binder General Requirements section for more information about QHP binder filings.
  - 2. Qualified Dental Plans (QDPs): Issuers must file a binder containing all QDP data necessary for all stand-alone dental plans that provide pediatric dental benefits as one of the Essential Health Benefits (EHBs). See the QDP Binder General Requirements for more information about QDP binder filings.
- B. Binder Name field must include the plan year.
- C. Only one binder per market per issuer license may be filed.
- D. Binder filings must include all required documents identified in these instructions and in Exhibit A.
- E. Issuers must add "Accrediting Entity" identifiers on the Company and Contact tab.
  - 1. **If a URAQ ID is added after the Binder has been created, it will not be reflected in the Binder.** See the QHP Company and Contact Tab section for more details.
  - 2. Issuers accredited through NCQA must add proof of their accreditation status under the Supporting Documentation tab in SERFF as NCQA will no longer be providing accreditation information to the NAIC for inclusion in the SERFF binders.
- F. NAIC Uniform Transmittal Forms are not required when submitting SERFF filings.
- G. Network access reports must not be filed in SERFF.
- H. Issuers must file product form and rate filings in SERFF before creating the binder filing in order to associate the rate and form filings in the binder filing.
  - 1. The "Associate Schedule Items" tab in the binder filing must be used to identify the corresponding form and rate filings.
    - a. You must use the same Electronic Funds Transfer (EFT) instance to file Product, Rate and Binder submissions. *SERFF will not support the Associate Schedule Items tab across multiple instances.*
    - b. Your binder submission is a "For-Public" record. Do not associate proprietary rate information.

2. Form, rate, and binder filings must all be consistent with one another. The single most effective way to expedite review is to compare the rate, form, and binder filings for consistency prior to submission. Finding and objecting to inconsistent information in corresponding filings is usually the most time-consuming part of the review process but can be prevented by a proactive issuer. We recommend all issuers proofread and compare their filings prior to submission.
  - a. If the Analyst determines that information in the binder does not match the information in the form or rate filing, the Analyst will send an objection indicating that there is an inconsistency and requesting that the issuer correct the filing(s).
  - b. If the Analyst finds that there are five or more inconsistencies between the form and the binder, the Analyst will cease review of the binder. The Analyst will send an objection indicating that review has ceased and request corrections.
  - c. Review of the binder will not resume until after corrections have been received.
  - d. If you receive an objection requesting correction of an inconsistency that occurs throughout the binder, you must correct that inconsistency in every place it occurs in the binder. For example, suppose a cost share is erroneously identified as occurring "after deductible" on one Cost Share Variance worksheet in the Plans and Benefits Template, while the forms indicate that the cost share occurs before the deductible. You must review each additional Cost Share Variance worksheet in the Template to ensure that the error is corrected everywhere it occurs.

## II. SERFF QHP Binder General Requirements

### A. SERFF Plans Tab

1. Timing of changes to a QHP binder filing:
  - a. You may make any changes to your binder filing that are required to be made in response to an objection in that filing. Those changes may be made at any time between receipt of the Objection Letter and the "respond-by" date in the Objection Letter.
  - b. The timing of changes to your binder filing for any other reason must be coordinated with the Analyst assigned to that filing. Failure to coordinate with your Analyst may interrupt (and thus delay) review of the filing or may require the Analyst to re-start review from the beginning. If you make a change that necessitates re-starting review from the beginning, that review will be prioritized according to the date of the change (not the date of the original filing). This will delay review of your filing.
  - c. To coordinate timing of changes with your Analyst, you must send a Note to Reviewer in the binder filing requesting to make the change. The Note to Reviewer must be sent in the filing you are requesting to change and include specific details of the change requested.
    - i. If you are requesting to make a change to your binder filing in response to an objection in the corresponding **rate or form** filing, your Note to Reviewer must also include the SERFF or State Tracker ID of that rate or form filing.
    - ii. Your Analyst will respond to your request in a Note to Filer. The Analyst may:
      - A. Authorize you to make the change immediately; or
      - B. Request that you make the change at a later time during the review process; or
      - C. Advise you of any specific compliance concerns about the change you have requested.
  - d. Do not make any modifications other than as specifically authorized in the Note to Filer. Filings modified without coordination with the Analyst may be treated as un-reviewed filings and prioritized according to the date of the unauthorized change (not the date of your original filing). This will delay review of your filing.
2. **Adding or removing plans – if you add or remove plans that cause a change to your HIOS Plan IDs in your binder filing, SERFF functionality may require you to submit a new binder to allow the change.**

### B. Associate Schedule Items Tab

1. You must build your QHP filings using the Associate Schedule Items feature for each plan.
2. You must associate the following documents for each plan:

- a. Exchange Products:
  - i. Application to be used for direct sale of Exchange health plans off the Exchange per consumer request;
  - ii. Policy;
  - iii. Schedule of Benefits
  - iv. Rate Schedule.
- b. Outside Market Products:
  - i. Application;
  - ii. Enrollment Form;
  - iii. Policy;
  - iv. Certificate of Coverage (Small Group Market);
  - v. Schedule of Benefits
  - vi. Rate Schedule.
- 3. You may not associate filing documents from different product submissions to build a plan. For example, you may not associate an application form from product filing 1, and policy form Y from product filing 2 to build a plan.
- 4. Do not associate supporting documents, such as, but not limited to: checklist, cover letters, certification forms, etc.
- 5. After adding, replacing, or removing documents in the form filings, make sure that the appropriate documents are associated in the binder filing.
- C. Supporting Documentation Tab
  - 1. The SBE attestation must be attached if any plans in the filing are offered on the Exchange.
  - 2. Do not submit the Uniform Product Modification Justification (UPMJ) documentation in the binder filing. **UPMJ documents should be submitted in the rate filing only.**
  - 3. You must complete and submit one snapshot document (provided by the OIC) in your binder filing. One snapshot should be completed for each binder filing and contain only information about the plans and filings corresponding to the binder filing in which it is submitted.
    - a. Medical issuers must use the snapshot document named "Snapshot - Binder - PY2024 Individual and Small Group Medical Filings (Duplicate).xlsm" to prepare their snapshot.
    - b. When submitting the snapshot in the binder, the issuer must provide both a PDF and Excel version:
      - i. Name the PDF file, "[Individual or Small Group] Medical Snapshot.pdf"

- ii. Name the Excel file, "[Individual or Small Group] Medical Snapshot Duplicate.xlsx."
- 4. **Data Integrity Tool (DIT) Results:** You must submit a screenshot of your Data Integrity Tool (DIT) results. You must provide justification for each error shown in your DIT results.
- 5. **Electronic Review Tool Results**
  - a. You must run the 2024 Category & Class Drug Count Review Tool and the Non-Discrimination Clinical Appropriateness Tool (part of the Formulary Review Suite) and report the results for each of your formularies. Within the Cost Sharing Tool, you must also run the Maximum Out-of-Pocket review and the Catastrophic Plans review (if applicable) and report the results for each of your plans. For your convenience, Submission Requirement sections have been added to the Supporting Documentation tab in SERFF for these results.
    - i. Note that each of the tools includes detailed instructions. Please refer to these instructions in running the tools.
    - ii. You must attach the entire Excel workbook showing your tool results.
  - b. **Category & Class Drug Count Review Results**
    - i. When running the Category & Class Drug Count Review Tool, **you must import the Plans and Benefits Template data from the Master Review Tool.** This is necessary so that the tools show results at the plan level and will remove any unused drug lists.
    - ii. You must attach the entire Excel Workbook showing results for each Formulary in each market.
    - iii. The Excel Workbook with these results must show that each Drug List has passed the Tool (or passed with justification). For each Category Class of drugs that does not meet the EHB benchmark, you must submit your justification. The EHB benchmark is either the Benchmark Count or the Benchmark Reevaluation count indicated on the Tool, whichever is higher.
    - iv. If you make changes to your Drug List based upon the Tool results, you must run the tool again on the changed drug list and submit the results based on the changed drug list. You may not provide the original results with a justification indicating you have added a drug to the list to meet the benchmark unless the drug added is not on the HHS EHB Rx Crosswalk.
    - v. A "passed" result means that the number of covered drugs in each Category Class meets or exceeds either the Benchmark Count or the Benchmark Reevaluation count.
    - vi. Justifications must be submitted using the Washington state "Formulary - Category & Class Drug Count Review Tool Supporting Documentation and Justification" form, which is available on our website at: <https://www.insurance.wa.gov/health-coverage-filing-instructions>. **Please do not**

**use the Justification form provided by CCIIO. Note: Justification forms must be converted to a PDF format prior to uploading in SERFF. DO NOT upload the WORD version.**

- vii. If a drug list does not meet the EHB benchmark in a Category Class and your justification is not sufficient as determined by the OIC, you must add sufficient drugs to the drug list to meet the EHB benchmark.

**c. Non-Discrimination Clinical Appropriateness Tool Results**

- i. This is one of the two tools that comprise the Formulary Review Suite (FRS). Each binder filing must include the Excel Workbook showing that each formulary included in that binder has passed the Non-Discrimination Clinical Appropriateness Tool (or passed with justification). (Note that the Non-Discrimination Formulary Outlier Tool results are not required to be submitted because that tool will not produce meaningful results when run on fewer than 5 drug lists).
- ii. Inputs for the FRS's dialog boxes
  - A. The first dialog box for this tool asks, "Do you have separate individual and SHOP Prescription Drug Templates?" Leave the default answer "No".
  - B. The third dialog box asks whether you wish to import Master Review Tool data. Leave the default answer "Yes". When running the Non-Discrimination Clinical Appropriateness Tool, **you must import the Plans and Benefits Template data from the Master Review Tool**. This is necessary so that the tool shows results at the plan level and will remove any unused drug lists.
  - C. The fourth dialog box asks, "Would you like to run all formulary reviews together?" You may run the suite together or separately, as desired. Only the results of the Non-Discrimination Clinical Appropriateness Tool must be attached to your binder filing.
  - D. When you click on the green "Run Formulary Review Suite" button, a dialog box appears asking whether you want to adjust the thresholds or use the default thresholds. Click on "Default Thresholds."
- iii. Reporting Non-Discrimination Clinical Appropriateness Tool results
  - A. You must include the entire Excel Workbook showing results of the Non-Discrimination Clinical Appropriateness Tool for each formulary in the binder. If the results show that all formularies have passed the tool, the Workbook is all you must submit.
  - B. The "Clinically Appropriateness Details" worksheet shows results for each condition and drug class being reviewed and identifies areas where drug coverage does not meet or exceed the applied threshold. Each cell associated with a result of "not met" will be in bold with red font.

- C. For any Condition and Class that does not meet the State threshold, you must submit a justification using the Washington state "Formulary - Non-Discrimination Clinical Appropriateness Tool Supporting Documentation and Justification" form, which is available on our website at:  
<https://www.insurance.wa.gov/health-coverage-filing-instructions>. **Please do not use the Justification form provided by CCIIO. Note: Justification forms must be converted to a PDF format prior to uploading in SERFF. DO NOT upload the WORD version.**
- D. For each Condition and Class that was not met, you must use these documents to justify why your benefit design is not discriminatory even though it does not meet the State threshold for clinically appropriate drug coverage in that Condition and Class.
  - 1. If a Condition and Class does not meet the State threshold and your benefit design is found to be discriminatory (in other words, if your justification(s) is(are) not sufficient as determined by OIC), you must add unrestricted drugs or remove drug restrictions sufficient enough to meet the State threshold for that Condition and Class.
  - 2. If you make changes to your drug list based upon the Tool results, you must run the tool again on the changed drug list. You may not provide the original results with a justification indicating you have added a drug to the list to meet the benchmark unless the drug added is not on the HHS EHB Rx Crosswalk.
- d. **Cost Sharing Tool Results**
  - i. You must run the Maximum Out of Pocket (MOOP) Review on each of the plans in your binder. If your binder includes any Catastrophic plans, you must run the Catastrophic Plan Review tool on those plans. The Cost Sharing Tool requires input from the Master Review Tool. The Cost Sharing Tool will run 5 different checks on your entire portfolio at once. You may perform all 5 checks, or you may perform only the Maximum Out of Pocket Review and, if applicable, the Catastrophic Plan Review.
  - ii. You must run the review tools using the default values.
  - iii. You must submit the entire Excel Workbook showing that each plan in your binder has passed the MOOP Review and, if applicable, the Catastrophic Plan Review.
- e. **Non-Discrimination Benefit Review Tool**
  - i. Issuers should not run the Non-Discrimination Benefit Review Tool or submit results.



- ii. Because this is a market-wide tool, OIC will run this tool when all Washington plans for Plan Year 2024 have been filed. The tool can only be run once in order to avoid creating a moving target. We will be using the default values in the tool.
  - iii. If any of your plans show outliers, you may be asked to correct or justify your benefit design.
- 6. You may submit the following 2024 "QHP Application Justification Documents":
  - a. "Unique Plan Design - Supporting Documentation and Justification"
  - b. Washington state "Formulary - Category & Class Drug Count Review Tool Supporting Documentation and Justification form."
  - c. Washington State "Formulary - Non-Discrimination Clinical Appropriateness Tool Supporting Documentation and Justification" form.
- 7. If your Plans and Benefits Template (PBT) contains plans that have unique plan designs as indicated on the Cost-Share Variances worksheet of the PBT, you must complete and submit a Unique Plan Design Benefit Crosswalk for each plan that qualifies.
  - a. Issuers should use the "Checklist - Binder - PY2024 Individual and Small Group- Unique Plan Design Benefit Crosswalk" document. Submit a PDF version of the Unique Plan Design Benefit Crosswalk in the binder filing only.

D. Templates Tab

You must complete the templates according to the 2024 "QHP Application Instructions" guide unless given other specific guidance by the OIC.

- 1. Essential Community Provider/Network Adequacy Template
  - a. The Essential Community Provider/Network Adequacy template and Network ID template are interdependent. You must import the Network IDs template into the ECP/Network Adequacy Template.
  - b. You must complete the essential community provider (ECP) section of the template following Instructions for the Essential Community Providers/Network Adequacy Application Section (2E) and Instructions for Network Identification Application.
  - c. Washington state **does not** use the network adequacy data side on the ECP/NA template. To complete the Network Adequacy (NA) section of the template for validation purposes, open the "User Control" tab and create both the "Individual Providers (NA)" and "Facility Providers (NA)" tabs. Enter one single dummy data record for the Individual Provider (NA) and Facility Provider (NA) tabs. Washington State will not be using this template section for review. Templates received with this section completed will not be accepted; you will be asked to resubmit the template without this section completed.

- d. Only essential community providers who have signed an approved provider contract may be identified on the template. **Do not** list providers who have not signed a provider contract. Letter of Agreement to Contract and Letter of Understanding **are not** provider contracts and may not be used to illustrate the possibility that an essential community provider may sign a contract.
- 2. Business Rule Template
    - a. This template must be the same for all binders of the same insurance type.
      - i. This includes individual and small group binders for medical and dental TOIs.
      - ii. Medical filings with embedded dental must include medical and dental business rules.
- 3. Rate Data Template
    - a. If rates in the corresponding rate filing change, you must also update the rates in the Rate Data Template. If an objection letter is active in the binder filing, update the Rate Data Template when responding to the objection letter. If an objection letter is not active, request to update the Rate Data Template via a Note to Reviewer; after receiving a response to the Note to Review, proceed as instructed in the response.
- 4. Plans & Benefits Template, Service Area Template, Prescription Drug Template and Network Template
    - a. Note that the Plans & Benefits Template, Service Area Template, Prescription Drug Template, and Network template are interdependent. You must complete the Service Area Template, Prescription Drug Template and Network Template **before** creating the Plans & Benefits Template. You must import the IDs created in the Service Area Template, Prescription Drug Template and Network Template into the Plans & Benefits Template.
    - b. Network Template
      - i. You must submit the same Network ID Template in all binder filings from the carrier for PY2024 plans offered in Washington State. The contents of the Network ID Template must match across the binder filings.
      - ii. You must use a unique Network ID for each combination of market type (Individual Market networks or Small Group Market networks) and plan coverage type (health plan or dental plan).
      - iii. Each plan can only be associated with one Network ID, but a Network ID can be associated with multiple plans.
    - c. Service Area Template
      - i. You must submit the same Service Area Template in all binder filings from the carrier for PY2024 plans offered in Washington State. The contents of the Service Area Template must match across the binder filings.

- ii. You must use unique Service Area IDs for each combination of service area, market (individual or small group), and plan coverage type. See the following examples:
  - A. You may NOT use the same Service Area ID in the individual and small group market (see the QHP Application Instructions for the Service Area template for details).
  - B. You may NOT use the same service area ID for a QHP and a QDP.
- iii. You must include the word "dental" in the dental service area names, to distinguish them from health service areas.
- iv. Each plan can only be associated with one Service Area ID, but a Service Area ID can be associated with multiple plans.
- d. Prescription Drug Template
  - i. You must complete the Prescription Drug Template, listing every covered drug including Medical Service Drugs.
    - A. Each drug list may have only one tier structure, as indicated by numbers of tiers and drug tier types, and all formularies associated with each drug list must be identical.
    - B. All plans within the same product must use the same formulary. Please note that for plans within the same product, plans may have different formulary IDs if such differences are only due to variations in cost-sharing requirements of the plans.
    - C. You must create separate formulary IDs for each market (Individual or Small Group) and use the same Prescription Drug Template across all binders OR ensure that no formulary IDs repeat across the binders.
    - D. In order to demonstrate compliance with the prescription drug Essential Health Benefit, every covered drug must be included in the applicable drug list for each plan. If a drug is not listed on the drug list for a formulary, this means the drug is not covered under plans using that formulary. This includes all covered Medical Service Drugs.
      - 1. "Medical Service Drugs" are drugs which are only administered in a clinical setting, such as Monoclonal Antibodies, Hemophilia clotting factors, and certain cancer chemotherapy drugs.
    - E. For each formulary, all covered Medical Service Drugs must be included in the drug list for that formulary on the Drug List worksheet of the Prescription Drug Template.

1. The Drug Tier Type column (Column F) on the Formulary Tiers worksheet of the Prescription Drug Template allows you to create a tier for Medical Service Drugs. If a drug is available only as a Medical Service Drug you may use this drug tier type to reflect that.
2. You are not required to create a separate Medical Service Drug Tier. If you choose not to, or are unable to, list Medical Service Drugs as a separate tier (for example, if your formulary already includes the maximum 7 tiers), you need only ensure that the coverage conditions for these drugs are reflected accurately. If you are unsure how to accomplish that within the functionality of the Prescription Drug Template, please contact your Forms Analyst to determine how to accurately reflect each plan's coverage of Medical Service Drugs.
3. The Prescription Drug Template will only allow you to list drugs by RxCUI. Some issuers have reported that their plans cover medical service drugs which the issuers are unable to list by RxCUI. You may list any covered medical service drug which does not have an RxCUI on a separate Excel Spreadsheet attached on the Supporting Documentation tab, and identify the drug by J-code. However, if the drug has an RxCUI, you must list it by RxCUI on the Drug List worksheet of the Prescription Drug Template.

e. **Plans & Benefits Template**

- i. **HIOS Plan IDs:** You must use unique HIOS Plan IDs for your plans. You must use new HIOS Plan IDs for new plans. You may NOT reuse old HIOS Plan IDs.
- ii. **Formulary IDs:** All plans within the same product must have the same formulary. Please note that for plans within the same product, plans may have different formulary IDs if such differences are only due to variations in cost-sharing requirements of the plans. In other words, different formulary IDs associated with your plans in the QHP Prescription Drug and Plans & Benefits templates do not necessarily trigger different products.
- iii. **Network IDs:** You must use unique Network IDs for each combination of market (individual or small group), and plan coverage type (QHP or QDP).
- iv. **Service Area IDs:** You must use unique Service Area IDs for each combination of service area, market (individual or small group), and plan coverage type (QHP or QDP).
- v. **QHP/Non-QHP:** If a plan is not marketed on the Exchange, enter "Off the Exchange." If a plan is marketed on the Exchange (including Standardized plans), enter "Both," except for catastrophic health plans. For catastrophic health plans, enter "On the Exchange." See the following excerpt from page 2D-5 of the Qualified Health Plan Issuer Application Instructions:

Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following:

- ◆ **On the Exchange**—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select **Both** unless an exception to guaranteed availability applies.
- ◆ **Off the Exchange**—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange for purposes of the risk corridor program (see 45 CFR 153.500 for more details).
- ◆ **Both**—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.

vi. **Cascade Care Standardized and Public Option Health Plans**

- A. Plan naming convention for the Plan Marketing Name field of the Plans and benefits Template
  1. For **standardized health plans**, use the naming convention: “[Issuer Name] Cascade [Metal Level]”
    - a. Example: “Issuer1 Cascade Silver”
  2. For **public option health plans**, use the naming convention: “[Issuer Name] Cascade Select [Metal Level]”
    - a. Example: “Issuer1 Cascade Select Silver”
- B. Issuers must use the same naming conventions in the corresponding Plan Variant Marketing Name field of the Cost Share Variances worksheet for all plan variants. Issuers may not add additional elements without receiving approval from the Exchange (see below).
- C. An issuer must contact the Exchange directly to discuss and receive approval from the Exchange to use additional identifying elements or plan marketing names in the naming conventions listed in A1, A2, and B above.
  1. Approvals received from the Exchange must be attached to the corresponding form filing’s Supporting Documentation tab.

vii. **Plan Variant Marketing Names:** Please see the following excerpt from page 2G-19 of the “Qualified Health Plan Issuer Application Instructions: Plan Year 2024”:

45 CFR 156.225, as finalized in the HHS Notice of Benefit and Payment Parameters for 2024, requires that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. Issuers may, but are not required to, add cost sharing and/or other benefit information to a plan marketing name here. This information must:

- Accurately reflect the plan variant's benefits, including any quantitative limits (see Section 4.8) and limitations or cost variations based on tiering, benefit category, or service type. For example:
  - Plan Variant Marketing Names that list a non-integrated deductible or MOOP must specify if the deductible refers to "Medical" or "Drug," remove references to a deductible or MOOP, or list the combined deductible or MOOP amount. If including a number without a modifier that refers to a deductible or MOOP, we encourage issuers to include the full amount for which an enrollee may be responsible.
  - Cost-sharing information must include any applicable limitations to a certain prescription drug category, specific providers, or to a certain number of visits.
- Correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and/or in other materials submitted as part of the QHP certification process such as the Summary of Benefits and Coverage (SBC).
- Be consistent with and clearly resemble the plan or plan variant name in other plan documents, such as the SBC, even if it is not identical.
- Not include references to benefits that the PPACA requires all QHPs to cover as though they were unique to that plan, such as "free preventive care" or "no exclusions for pre-existing conditions."
- Not indicate health savings account (HSA) eligibility if the plan is not a High Deductible Health Plan (HDHP).
- Not exceed 150 characters.

viii. A visit limit is considered a "benefit" in the definition of "product" and NOT a "cost-sharing structure" in the definition of "plan."

- ix. Child Only Plans. You must use a separate line on each worksheet for each child only plan. Indicate on the Child Only Offering field that the plan is child only. Enter the child only plan's Standard Component ID in the Child Only Plan ID for the corresponding adult only offering.
- x. Benefit Specific Instructions. After applying the WA Add-In file (Note: Washington state does not use the "PY2024 Standardized Options Add-in" file), the Essential Health Benefits (EHB) data is automatically entered into the sheet using the "Refresh EHB button." The Plan Benefits Add-In file for plan year 2024 requires manual modifications to meet individual state standards. The OIC has reviewed the Washington-specific content on the CMS Plan Benefits Revised Benchmark instructions and identified a few additional requirement modifications.

Apply the changes as identified in the market-specific benefits benchmark files:

- Exhibit B: Washington EHBs on the 2024 Plans & Benefits Template

- Exhibit C: Visual Maps of PBT with Washington EHBs

**Note:** Exhibits B and C are separate documents that can be found on SERFF: Plan Management tab, Plan Management General Instructions section for Washington. They are also available at: <https://www.insurance.wa.gov/health-coverage-filing-instructions>.

- xi. For **non-preferred brand drugs**, please refer to the QHP Application Instructions (see Section 2G, Subsection 5.8 and Appendix A, Subsection 5.11.5).
- xii. **Virtual Visits/Care at Difference Cost-Shares:** For plans that offer different cost-sharing for virtual care, corresponding to a limited number of benefit categories, you may indicate cost-share difference for virtual visits in the Benefit Information column of the corresponding benefit category on the Benefits Package worksheet. Otherwise, if a plan's virtual care cost-share differences result in a two completely separate in-network plan tiers, the plan should use another tier in the Cost Share Variance worksheet to reflect the plan design.
- xiii. **Benefits Package Tab "EHB Variance Reason" (Column J): "Substituted," "Substantially Equal," and "Using Alternate Benchmark" are not acceptable variance reasons in Washington State.**
- xiv. **Design Type:** Enter "Not Applicable" for all plans. This field is not currently applicable to Washington plans.

E. Company and Contact Tab

1. Issuers must add "Accrediting Entity" identifiers in Company Information and Accreditation Information sections of the Company and Contact Tab. Enter either the NCQA Org ID (the number assigned by NCQA when an issuer applies for accreditation) and/or a URAC App Number (the identifier assigned by URAC when an issuer applies for accreditation). The Accreditation IDs are entered on the Company maintenance screen. **If a URAQ ID is added in SERFF after the Binder has been created, it will not be reflected on the Binder filing. Therefore, the URAQ ID must be added to the filer's Company Information prior to creating a binder filing. Issuers accredited through NCQA must, in addition to adding the NCQA Org ID on the Company and Contact tab, add proof of their accreditation status under the Supporting Documentation tab in SERFF as NCQA will no longer be providing accreditation information to the NAIC for inclusion in the SERFF binders.**

### III. SERFF QDP Binder General Requirements

#### A. Plans Tab

1. Timing of changes to a QDP binder filing:
  - a. You may make any changes to your binder filing that are required to be made in response to an objection in that filing. Those changes may be made at any time between receipt of the Objection Letter and the "respond-by" date in the Objection Letter.
  - b. The timing of changes to your binder filing for any other reason must be coordinated with the Analyst assigned to that filing. Failure to coordinate with your Analyst may interrupt (and thus delay) review of the filing or may require the Analyst to re-start review from the beginning. If you make a change that necessitates re-starting review from the beginning, that review will be prioritized according to the date of the change (not the date of the original filing). This will delay review of your filing.
  - c. To coordinate timing of changes with your Analyst, you must send a Note to Reviewer in the binder filing requesting to make the change. The Note to Reviewer must be sent in the filing you are requesting to change and include specific details of the change requested.
    - i. If you are requesting to make a change to your binder filing in response to an objection in the corresponding rate or form filing, your Note to Reviewer must also include the SERFF or State Tracker ID of that rate or form filing.
    - ii. Your Analyst will respond to your request in a Note to Filer. The Analyst may:
      - A. Authorize you to make the change immediately; or
      - B. Request that you make the change at a later time during the review process; or
      - C. Advise you of any specific compliance concerns about the change you have requested.
  - d. Do not make any modifications other than as specifically authorized in the Note to Filer. Filings modified without coordination with the Analyst may be treated as un-reviewed filings and prioritized according to the date of the unauthorized change (not the date of your original filing). This will delay review of your filing.

#### B. Associate Schedule Items Tab

1. You must build your QDP filings using the Associate Schedule Items feature for each plan you intend to offer.
2. You must associate the following documents for each plan:
  - a. Exchange Products:
    - i. Policy;
    - ii. Schedule of Benefits;
    - iii. Rate Schedule.



- b. Outside Market Products:
  - i. Application;
  - ii. Enrollment Form (Small Group Market);
  - iii. Policy;
  - iv. Certificate of Coverage (Small Group Market);
  - v. Schedule of Benefits
  - vi. Rate Schedule.
- 3. You may not associate filing documents from different product submissions to build a plan. For example, you may not associate an application form from product filing 1, and policy form Y from product filing 2 to build a plan.
- 4. Do not associate supporting documents such as, but not limited to, the following: checklist, cover letters, certification forms, etc.
- C. Supporting Documentation Tab
  - 1. The SBE attestation must be attached if any plans in the filing are offered on the Exchange.
  - 2. You must submit requested documents or attachments as Supporting Documentation.
  - 3. The following "QHP Application Justification Documents" are no longer required in the binder filing:
    - a. "Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification"
    - b. "Stand-Alone Dental Plan – Description of EHB Allocation"

While these documents are no longer required in the binder, the actuarial memorandum in the corresponding rate filing submission should address the EHB allocation information and should be consistent with the "EHB Apportionment for Pediatric Dental" entries in the Plans and Benefits Template.
  - 4. You must complete and submit in your binder filing one snapshot document provided by the OIC. One snapshot should be completed for each binder filing and contain only information about the plans and filings corresponding to the binder filing in which it is submitted.
    - a. Dental issuers must use the snapshot document named "Snapshot - Binder - PY2024 Individual and Small Group Dental Filings (Duplicate).xlsm" document to prepare their snapshot.
    - b. When submitting the snapshot in the binder, the issuer must provide both a PDF and Excel version:
      - i. Name the PDF file, "[Individual or Small Group] Stand-Alone Dental Snapshot.pdf"

- ii. Name the Excel file, "[Individual or Small Group] Stand-Alone Dental Snapshot Duplicate.xlsx"
5. You must submit a screenshot of your Data Integrity Tool (DIT) results. You must provide justification for each error shown in your DIT results.

D. Templates Tab

You must complete the following templates using the 2024 "QHP Application Instructions".

1. Essential Community Provider/Network Adequacy Template
  - a. The Essential Community Providers/Network Adequacy template and Network ID template are interdependent. You must import the Network IDs template into the ECP/Network Adequacy Template.
  - b. You must complete the essential community provider (ECP) section of the template following Instructions for the Essential Community Providers/Network Adequacy Application Section (2E) and Instructions for Network Identification Application.
  - c. Washington state **does not** use the network adequacy data side on the ECP/NA template. To complete the Network Adequacy (NA) section of the template for validation purposes, open the "User Control" tab and create both the "Individual Providers (NA)" and "Facility Providers (NA)" tabs. Enter one single dummy data record for the Individual Provider (NA) and Facility Provider (NA) tabs Washington State will not be using this template section for review. Templates received with this section completed will not be accepted; you will be asked to resubmit the template without this section completed.
  - d. Only essential community providers who have signed an approved provider contract may be identified on the template. **Do not** list providers who have not signed a provider contract. Letter of Agreement to Contract and Letter of Understanding **are not** provider contracts and may not be used to illustrate the possibility that an essential community provider may sign a contract.
2. Business Rule Template
  - a. This template must be the same for all binders of the same insurance type.
    - i. This includes individual and small group binders for medical and dental TOIs.
    - ii. Medical filings with embedded dental must include medical and dental business rules.
3. Rate Data Template
  - a. If rates in the corresponding rate filing change, you must also update the rates in the Rate Data Template. If an objection letter is active in the binder filing, update the Rate Data Template when responding to the objection letter. If an objection letter is not active, request to update the Rate Data Template via a Note to Reviewer; after receiving a response to the Note to Reviewer, proceed as instructed in the response.

4. Plans & Benefits Template, Service Area Template and Network Template
  - a. The Plans & Benefits Template, Service Area Template, and Network template are interdependent. You must complete the Service Area Template and Network Template **before** creating the Plans & Benefits Template. You must import the IDs created in the Service Area Template and Network Template into the Plans & Benefits Template.
  - b. Network Template
    - i. You must submit the same Network ID Template in all binder filings from the carrier for PY2024 plans offered in Washington State. The contents of the Network ID Template must match across the binder filings.
    - ii. You must use a unique Network ID for each combination of market type (Individual Market networks or Small Group Market networks) and plan coverage type (health plan or dental plan).
    - iii. Each plan can only be associated with one Network ID, but a Network ID can be associated with multiple plans.
  - c. Service Area Template
    - i. You must submit the same Service Area Template in all binder filings from the carrier for PY2024 plans offered in Washington State. The contents of the Service Area Template must match across the binder filings.
    - ii. You must use unique Service Area IDs for each combination of service area, market (individual or small group), and plan coverage type. See the following examples:
      - A. You may NOT use the same Service Area ID in the individual and small group market (see the QHP Application Instructions for the Service Area template for details).
      - B. You may NOT use the same service area ID for a QHP and a QDP.
    - iii. You must include the word "dental" in the dental service area names, to distinguish them from health service areas.
    - iv. Each plan can only be associated with one Service Area ID, but a Service Area ID can be associated with multiple plans.
  - d. You must complete the Plans & Benefits Template.
    - i. **Benefits Package Tab "EHB Variance Reason" (Column J): "Substituted," "Substantially Equal," and "Using Alternate Benchmark" are not acceptable variance reasons in Washington State.**
    - ii. A visit limit is considered a "benefit" in the definition of "product" and NOT a "cost-sharing structure" in the definition of "plan."

- iii. Child Only Plans. You must use a separate line on each worksheet for each child only plan. Indicate on the Child Only Offering field that the plan is child only. Enter the child only plan's Standard Component ID in the Child Only Plan ID for the corresponding adult only offering.

Benefit Specific Instructions. After applying the WA Add-In file (Note: Washington state does not use the "PY2024 *Standardized Plan Design Add-In*" file), the Essential Health Benefits (EHB) data is automatically entered into the sheet using the "Refresh EHB button". The Plans & Benefits Add-In file for plan year 2024 requires manual modifications to meet individual state standards. The modifications required in Washington State are identified and explained in the following documents.

- Exhibit B: Washington EHBs on the 2024 Plans & Benefits Template
- Exhibit C: Visual Maps of PBT with Washington EHBs

**Note:** Exhibits B and C are separate documents that can be found on SERFF: Plan Management tab, Plan Management General Instructions section for Washington. They are also available by clicking: <https://www.insurance.wa.gov/health-coverage-filing-instructions>.

#### IV. Quarterly Formulary Filings [WAC 284-43-5642(6)(e)(i)]

- A. Issuers who file non-grandfathered individual and small group plans must file their formularies quarterly in the current plan year's binder only. **Note: This section does not apply to Student Health Plans under TOI H22 (Please refer to the *Washington State SERFF Health and Disability Form Filing General Instructions*, Section VI.B, for instructions regarding filing formularies for Student Health Plans).**
- B. When to file:
  - 1. For non-grandfathered individual and small group health plans the 1st quarter formularies are filed as part of the annual binder filing.
  - 2. For all non-grandfathered individual and small group health plans the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarter formularies must be filed in .xls format prior to the beginning of the quarter during which they will be in effect. (NOTE: The Exchange requires both an .xml and .xls version of the Prescription Drug Template.) Therefore, the 2nd quarter filings are due prior to April 1, the 3rd quarter filings are due prior to July 1, and the 4th quarter filings are due prior to October 1. For your convenience, Submission Requirement sections have been added to the Supporting Documentation tab in SERFF for these quarterly results. Quarterly formulary documentation must be loaded under the applicable quarter located in the submission requirement section on the Supporting Documentation tab. Do not create new sections or place the documentation in any other place on the tab.
- C. You must file each quarterly formulary using the Prescription Drug Template published by CCIO in your Binder filing for that Plan Year. Keep in mind that the Prescription Drug Templates used for quarterly formulary filings do not need to be validated by CCIO and should not be attached to the Templates tab. The Formulary Tiers worksheet must not change from the 1<sup>st</sup> quarter's Template originally filed through the OIC.
  - 1. Issuers of non-grandfathered individual and small group health plans must file each quarterly formulary using the Prescription Drug Template published by CCIO for that plan year. For example, formularies for the 1<sup>st</sup> quarter of the 2024 Plan Year will be filed as part of the Binder using the Prescription Drug Template for Plan Year 2024. The 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> quarter 2024 formularies for those plans will be filed using the same version of the Prescription Drug Template.
  - 2. You can obtain the Template and the instructions for completing it at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html#Instructions, Templates and Materials>
  - 3. A copy of the updated Prescription Drug Template must be attached to the Supporting Documentation tab in .xls format for outside market plans. Binders that include plans to be sold on the Exchange require both an .xml and .xls version of the Prescription Drug Template (this includes plans to be sold both on and off the Exchange).

**D. Electronic Review Tool Results**

1. For each non-grandfathered individual and small group quarterly formulary filing, you must run the current Category & Class Drug Count Review Tool and the Non-Discrimination Clinical Appropriateness Tool (part of the Formulary Review Suite). You must report the results for each of your quarterly formularies.
  - a. Note that each of the tools includes detailed instructions. Please refer to these instructions in running the tools. (The Formulary Review Suite detailed instructions are a PDF document included in the folder called "Prescription Drug Reference Filed.")
  - b. The entire Excel workbook of tool results must be submitted by attaching the Workbook on the Supporting Documentation tab.
2. **Category & Class Drug Count Review results**
  - a. When running the Category & Class Drug Count Review tool, **you must import the Plans & Benefits Template data from the Master Review Tool**. This is necessary so that the tools show results at the plan level and will remove any unused drug lists.
  - b. Submit the entire Excel Workbook showing results for each Formulary in each market by attaching it on the Supporting Documentation tab under the applicable Submission Requirement section.
  - c. Your formulary filing must include documentation showing that each drug list has passed the tool (or passed with justification). For each Category Class of drugs that does not meet the EHB benchmark, you must submit your justification. The EHB benchmark is either the Benchmark Count or the Benchmark Reevaluation count indicated on the Tool, whichever is higher.
    - i. If you make changes to your drug list based upon the Tool results, you must run the tool again on the changed drug list and submit the results based on the changed drug list. You may not provide the original results with a justification indicating you have added a drug to the list to meet the benchmark unless the drug added is not on the HHS EHB Rx Crosswalk.
    - ii. A "passed" result means that the number of covered drugs in each Category Class meets or exceeds either the Benchmark Count or the Benchmark Reevaluation count.
  - d. Justifications must be submitted using the Washington state "Formulary - Category & Class Drug Count Review Tool Supporting Documentation and Justification" form, which is available on our website at: <https://www.insurance.wa.gov/health-coverage-filing-instructions>. **Please do not use the Justification form provided by CCIIO. Note: Justification forms must be converted to a PDF format prior to uploading in SERFF. DO NOT upload the WORD version.**
  - e. If a drug list does not meet the EHB benchmark in a Category Class and your justification is not sufficient as determined by the OIC, you must add sufficient drugs to the drug list to meet the EHB benchmark.
3. **Non-Discrimination Clinical Appropriateness Tool Results**

- a. This is one of the two tools that comprise the Formulary Review Suite (FRS). (Note that the Non-Discrimination Formulary Outlier Tool results are not required to be submitted because that tool will not produce meaningful results when run on fewer than 5 drug lists).
  - b. Submit the entire Excel Workbook showing results for each formulary in each market by attaching it on the Supporting Documentation tab under the applicable Submission Requirement section (for example, the second quarter formulary documentation should be listed "2<sup>nd</sup> Quarter (2024) Formulary Tool Results, Washington Justification Attestations, and Objection Letter Response").
  - c. Your formulary filing must include documentation showing that each formulary has passed the tool (or passed with justification). For any Condition and Class that does not meet the State Threshold, you must submit your justification.
    - i. If you make changes to your drug list based upon the Tool results, you must run the tool again on the changed drug list and submit the results based on the changed drug list. You may not provide the original results with a justification indicating you have added a drug to the list or removed a restriction to meet the benchmark unless the drug in question is not on the HHS EHB Rx Crosswalk.
  - d. Justifications must be submitted using the Washington state "Formulary - Non-Discrimination Clinical Appropriateness Tool Supporting Documentation and Justification" form, which is available on our website at:  
<https://www.insurance.wa.gov/health-coverage-filing-instructions>. **Please do not use the Justification form provided by CCIO. Note: Justification forms must be converted to a PDF format prior to uploading in SERFF. DO NOT upload the WORD version.**
  - e. Inputs for the FRS's dialog boxes.
    - i. The first dialog box for this tool asks, "Do you have separate individual and SHOP Prescription Drug Templates?" Leave the default answer "No."
    - ii. The third dialog box asks whether you wish to import Master Review Tool data. Leave the default answer "Yes." When running the Non-Discrimination Clinical Appropriateness Tool, **you must import the Plans & Benefits Template data from the Master Review Tool**. This is necessary so that the tool shows results at the plan level and will remove any unused drug lists.
    - iii. The fourth dialog box asks, "Would you like to run all formulary reviews together?" You may run the suite together or separately, as desired. Only the results of the Non-Discrimination Clinical Appropriateness Tool must be attached to your formulary filing.
    - iv. When you click on the green "Run Formulary Review Suite" button, a dialog box appears asking whether you want to adjust the thresholds or use the default thresholds. Click on "Default Thresholds."
  - f. If a formulary's unrestricted drug coverage does not meet the threshold for a Category Class for any condition, and the justification is not sufficient as determined by the OIC, you must add unrestricted drugs or remove drug restrictions sufficient to meet the State threshold for that Condition and Category Class.
4. **How to File Quarterly Formularies for the 2<sup>nd</sup>, 3<sup>rd</sup>, and 4<sup>th</sup> Quarters.**

- a. Due to SERFF functionality, quarterly formularies must be filed by adding them to your Binder filing for that market for that Plan Year.
  - i. When you are prepared to file your quarterly formularies, you must request permission to re-open your Binder filing for that market and Plan Year via a Note to Reviewer in SERFF.
    - A. For example, you would request to re-open your Individual Market Binder for Plan Year 2024 in order to file the 2nd quarter 2024 formulary for your Individual plans.
  - ii. OIC will notify you that the Binder filing has been re-opened and you may amend the filing via a Note to Filer in SERFF.
  - iii. Under the Supporting Documentation tab, locate the appropriate Submission Requirement for that quarter (i.e., "2<sup>nd</sup> Quarter (2024) Formulary Tool Results, Washington Justification Attestations, and Objection Letter Responses"). Attach the Excel Workbooks showing the results for each of the required Electronic Review tools, any required justifications, and the updated Prescription Drug Template for that quarter in .xls format for outside market plans and both .xml and .xls formats for plans to be sold on the Exchange (this includes plans to be sold both on and off the Exchange).
- 5. **Requirements to Include Covered Medical Service Drugs in Formulary Filings.**
  - a. In order to demonstrate compliance with the prescription drug Essential Health Benefit, every covered drug must be included in the applicable drug list for each plan. If a drug is not listed on the drug list for a formulary that means the drug is not covered under plans using that formulary. This includes all covered Medical Service drugs.
    - i. "Medical Service Drugs" are drugs which are only administered in a clinical setting, such as Monoclonal Antibodies, Hemophilia clotting factors, and certain cancer chemotherapy drugs.
  - b. For each formulary, all covered Medical Service Drugs must be included in the drug list for that formulary on the Drug List worksheet of the Prescription Drug Template.
    - i. The Drug Tier Type column (Column F) on the Formulary Tiers worksheet of the Prescription Drug Template allows you to create a tier for Medical Service Drugs. If a drug is available only as a Medical Service Drug you may use this drug tier type to reflect that.
    - ii. You are not required to create a separate Medical Service Drug Tier. If you choose not to, or are unable to, list Medical Service Drugs as a separate tier (for example, if your formulary already includes the maximum 7 tiers), you need only ensure that the coverage conditions for these drugs are reflected accurately. If you are unsure how to accomplish that within the functionality of the Prescription Drug Template, please contact your Forms Analyst to determine how to accurately reflect each plan's coverage of Medical Service Drugs.



- iii. The Prescription Drug Template will only allow you to list drugs by RxCUI. Some issuers have reported that their plans cover medical service drugs which the issuers are unable to list by RxCUI. You may list any covered medical service drug which does not have an RxCUI on a separate Excel Spreadsheet attached on the Supporting Documentation tab and identify the drug by J-code. However, if the drug has an RxCUI, you must list it by RxCUI on the Drug List worksheet of the Prescription Drug Template.

**V. Your Binder Filing is Incomplete and will be rejected if:**

- A. Your filing does not comply with chapters 284-44A, 284-46A, or 284-58 WAC.
- B. We cannot download your filing into our back office system.

There are a number of reasons why we cannot download filings into our back office system. One of the most common reasons is that an incorrect CoCode number is entered in the Filing Company Information, under the Companies and Contact Tab. This CoCode number is the same number as your company's 5-digit NAIC number.

- C. The Associate Schedule Items tab is bypassed or improperly completed. You will be given the opportunity to correct this section if needed. The filing will be rejected if the section is not corrected.
- D. The form or rate schedule items are associated across multiple EFT instances.
- E. The binder is submitted for multiple market types.
- F. The binder is submitted for multiple issuer licenses.
- G. Not all required templates are loaded.
- H. Not all required templates are loaded on the appropriate tab.
- I. Not all required supporting documentation files are attached on the Supporting Documentation tab. You will be given the opportunity to correct this section if needed. The filing will be rejected if the section is not corrected.
- J. For QHP's the Accrediting Entity identifier has not been added to the Company Profile.
- K. Rejected Filings will not be Re-Opened
  1. If the OIC Insurance Technician Unit rejects your filing, you must submit a new filing following the procedures in our Rejection Notice and General Instructions.

## **VI. SERFF Objection Letter Response Requirements for Binder Filings**

### **A. You may not submit a partial response to an objection letter.**

1. You must provide a complete Response Letter that addresses all objections listed in the objection letter. It is highly recommended that issuers use a single point of contact to respond to all issues presented in an objection letter. A partial response letter will cause your filing to be delayed and may require it to be closed without additional review.
- B. When you are requested to make corrections to your binder, you must make the correction on every worksheet in the binder where the error appears.
  1. Example 1: You are requested to change the entry in Column K on the Benefits Package worksheet to correctly reflect an EHB. You must ensure that you have correctly made the change on every Benefits Package worksheet in the binder.
  2. Example 2: Your Analyst has informed you that review of your primary review product is complete. The Analyst requests that you make all changes to the worksheets for the other products according to the changes made in the primary review product. You must ensure that you correctly make all the changes on every worksheet in the binder.
  3. If your Analyst finds that you have not made corrections in every worksheet of the binder, the Analyst will cease review of the binder. The Analyst will send an objection indicating that review has ceased and requesting a corrected binder.

## **VII. After a Final Disposition by OIC Analyst**

After final disposition by an OIC Analyst you may not change or correct the filing. You must make a new filing in SERFF.

## **VIII. Contact Information**

**For questions related to template filing completion, template validation and other procedures, contact:**

Exchange Operations Support Center (XSOC)

855-CMS-1515

[CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov)

**For questions related to the SERFF System, submission requirements, or general workflow issues, contact:**

SERFF Help Desk

816-783-8990

[serffhelp@naic.org](mailto:serffhelp@naic.org)

**For question related to Washington filing procedures, contact:**

Rates, Forms, and Provider Networks Help Desk

(360) 725-7111

[rfhelpdesk@oic.wa.gov](mailto:rfhelpdesk@oic.wa.gov)