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Comments on Initial Plan Data Collection to Support Qualified Health Plan (QHP) Certification and Other Financial Management and Exchange Operations / QHP Application Process

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Overall:

- Rethink the number of data elements collected. The number of data elements collected, and not used or displayed, is enormous. Completing the templates took huge amounts of man hours to fill out the templates. Transparency into the coding of the templates for data elements to be displayed on the Federally Facilitated Marketplace (FFM) web site would allow issuers to prepare and complete the templates more efficiently and accurately. For example, suggest being more transparent and highlighting templates that have known interdependencies and will require cross walks.
- Well in advance of the window, plans need to understand the coding from the templates to display on the FFM so that we can fill out and prepare the templates much more efficiently and accurately. As they exist, the templates were very manual, making entry and manipulation time-intensive and prone to error.
- The Centers for Medicare & Medicaid Services (CMS) should review overlap with Plan Finder submissions to eliminate duplication as Plan Finder submissions continue over 2014. Suggest CMS revises the Plan Finder.
- From a system perspective, SERFF (System for Electronic Rate and Form Filing) is a big problem when corrections include adding or subtracting component IDs. The submitter is required to manually add component IDs so there can be cross validation with the Plan and Benefits template. Once the binder is submitted, if additional component ID changes are required, a whole new binder has to be built—causing extra work and review that shouldn't be necessary if they would open the system to revisions or remove the necessity to manually add the component IDs.
- We recommend that future template iterations allow for a copy and paste functionality to significantly reduce man hours in creating templates. For example, when two plans are identical but with different networks, copy and paste would make it much faster to duplicate templates. Another example is an issuer who had to split the Rate templates for one state template into two because it was too big. It took the analyst over 30 minutes to copy the first plan ID, paste it, populate all ages for that plan ID, and then go back and copy the next plan ID. There can be more than 100 plan IDs. It would have taken seconds if he could have copied all the cells on the template.
- Determine implications of updating existing templates from 2014 submission to utilize existing data versus starting from scratch with new templates. Issuers will have automated a certain number of processes and will want a fairly consistent application process moving

forward to lower administrative burden, while also balancing the need for applying key updates based on lessons learned from the 2014 submission.

- State regulators' use of templates for purposes other than what is intended by CMS created significant re-work, and ultimately templates were not the best fit for some purposes. For FFM and State Partnership Marketplace (SPM) states, suggest that states and CMS work out their purposes for the templates, as well as processes in advance, so carriers know what to expect, who to go to, and in what order for approvals.
- More explanation of the uses of template cells would help with completion of entries. For instance, Cost-Sharing Reductions (CSR) Advance Payment is derived from more than one template, which can be confusing to those who only work on a single template.
- Regarding CMS question and answer (Q&A) sessions, suggest that information released in future Frequently Asked Questions (FAQs) documents cover everything that was discussed in the Q&A sessions (not just select Q&A). Currently, neither notes nor recordings from the sessions were available, which would have been helpful. It was difficult to validate guidance given in the sessions (e.g., difficult to write fast enough to capture all the information), and at times, there was contradictory information in a subsequent FAQs document or in another session. Information delivery needs to be streamlined, clear, documented for everyone, and timely. For example, when CMS collects questions during their QHP application webinars via REGTAP, suggest CMS document and publish the written FAQs documents within one or two business days post-session. Having the opportunity to ask questions live is valuable but needs to be usable.
- The Q&A sessions should be open forums (maybe streaming) and not limited to a small number of people. Often issuers needed multiple experts from their organizations to hear the information. It might be helpful to have the sessions limited to topic areas and/or templates so the right CMS experts and the right health plan experts can be on each call.
- Regarding the Q&A sessions, none of the questions asked by one issuer in the Q&A section of the webinar platform for webinar calls were ever answered. The technology allows the name of the user and question to be captured, and CMS has the user's email address from the log in. Suggest that questions asked in writing on webinars should be answered, with a response sent directly back to the person asking (and/or published for everyone) like a Help Desk ticket. If they are answered via a general FAQs document, the requestor/submitter of the question should receive an email letting him/her know what document/page the response is on. Publishing the written FAQs might resolve this.
- Suggest CMS include more experts on calls to address questions and ensure consistent guidance (e.g., not conflicting guidance) across calls.
- Make continued and better use of the CMS email blasts, which issuers have come to rely upon for critical updates.
- Suggest CMS re-evaluates how it responds to issuers submitting questions about the templates/QHP application, so CMS can provide answers/clear responses more quickly; there was slow response time on questions submitted via email (i.e., often one or even two weeks), which caused work delays for issuers.
- When CMS responds to a template/QHP application question via email, suggest that CMS include the original question along with the response. There were numerous instances in which CMS responded, without reference to the question, which caused confusion when issuers had submitted multiple questions and weren't sure which one CMS response was addressing.
- While having a dedicated CMS Account Manager/point person is helpful, issuers need a technical person who can answer technical questions and help resolve issues in a timely manner. Suggest that CMS Account Managers should have assigned technical contacts within CMS to reach out to help resolve issuer technical problems more efficiently.

- Suggest CMS have a live production environment for issuers to review plans and make corrections before the site goes live with the public. There wasn't a live production environment prior to release to the public to ensure plans showed correctly. Plan preview was a testing environment and didn't show all the fields. For example, pediatric dental didn't show up in the testing environment, and we weren't able to validate it; corrections weren't made in advance of public release.

Schedule/Timeline:

- Templates need to be finalized and tested prior to opening HIOS (Health Insurance Oversight System) for the QHP application.
- Suggest final regulations, instructions, and templates (e.g., all bugs fixed beforehand) are released 60-90 days before the application period opens (but no less than two weeks before). It was understandable that the first year would be a more fluid process. However, carriers are being asked to control costs more than ever to meet the needs of the market. The processes and rules for operating need to be firm prior to the recertification period, and carriers need time to plan and allocate appropriate resources.
- Suggest CMS align QHP template submission deadlines with the Internal Revenue Service (IRS) timeline for release of the final allowable out-of-pocket maximum amounts and ensure CMS provides issuers with enough time to rerun plans through the actuarial value (AV) calculator with the final IRS allowable maximums and adjust templates accordingly, which is time consuming. This past year, three business days before the QHP templates were due, there was a change to the final out-of-pocket maximums and that was not enough time.
- Plan preview should occur as early as possible (early August) and last for two weeks, assuming no system issues.
- Reevaluate the Help Desk ticket submission process for plan preview. There were a lot of errors during this process (e.g., assigning tickets to us that were from other issuers, losing tickets, and long turnaround times). Issuers need more direct access to someone who can help them quickly address issues.
- Continue the REGTAP calls (or similar format) to provide an overview of the templates and instructions—highlighting changes from the previous submission—prior to the submission window and daily open troubleshooting Q&A calls during the submission window. Those were very helpful.
- Release validation macros at the same time as the base templates so as to be clear about what the actionable rules will be.
- Suggest that SERFF Plan Management accessibility happen on the same timeline as HIOS; several states requiring QHP application submission via SERFF were delayed (by several weeks) in making the SERFF Plan Management module/templates and state requirements available to issuers.
- Help Desk tickets need to be resolved (not just responded to or escalated) within a reasonable time frame such as two to three business days maximum, unless the submission window is substantially expanded.

General Functionality:

- Key plan fields should never be made read-only (i.e., should not have to redo the Cost-Share Variance (CSV) if the component ID needs to change).
- Validating a template should not lock any fields (i.e., make them read only).
- Validation by the template should catch the same issues as SERFF/HIOS validation.
- Plan Preview mode on HIOS should have all the bugs fixed prior to carriers reviewing plans. Carriers should only have to review their plans once and then maybe review again when a new template with fixes is uploaded. Rework had to be done daily (when no new information

had been uploaded), and carriers were essentially testing and doing a quality review of the system. This was an enormous investment of time by Health Plans.
- General suggestions related to the QHP templates' functionality:
  - Build in ability to load plan names for the cost-sharing reduction (CSR) plans into the templates.
  - Allow for separate Summary of Benefits and Coverage (SBC) links at the CSR level. Whatever link was used for the base plan had to be used for the cost-share variations associated with it.
  - Create a fix around the issue of having benefits incorrectly identified on the QHP template as essential health benefits (EHBs) when they were not.
  - Create a fix around only being able to identify the base plans Health Savings Account (HSA) qualified when the CSRs associated were not.
  - Make templates more edit friendly, such as allowing removal of a plan or cut and paste functionality, so as to not have to rework the templates from scratch.
  - Make the Limitations and Exclusions or explanations cells less limiting; similarly suggest this again when dealing with Limitations and Exclusions for the CSR plans built off the base plans.
  - Create alternative option ("Not Applicable") for filling out the Copay and Coinsurance cells for every single benefit, as there are instances in which those don't apply.
  - Add "Copay per day" as an option for some intended benefits such as Inpatient Mental Health or Substance Abuse.

Administrative Template:
- Reconsider the value of the administrative template, specifically the number of fields that are collected and how they are used. For example, a substantial number of plan contacts were collected but not necessarily used as CMS indicated.
- Provide definitions for all contact names so plans can assign the appropriate parties.
- Use contact names that plans provide. Plans received phone calls and emails to individuals at their company who were not identified in the administrative template.
- We suggest using the Individual Segment main contact as the single point of contact so that person can triage within the company as required. Plans have requested emails not go to the Chief Executive Officer (CEO) directly; it would have been more efficient to go directly to the Individual Segment contact.

Service Area Template:
- Need clearer instructions around the service area template and how it impacts other templates.

Organizational Chart:
- Need clearer guidance on the requirements (i.e., are roles sufficient or names of individuals).

Essential Community Providers (ECP) Template:
- Need clearer instructions around the ECP template especially as it relates to combining with stand-alone dental plans (SADPs).

Prescription Drug Template:
- The use of the term "formulary" is confusing. CMS is asking issuers to provide information on cost sharing for prescription drugs, which would be better captured in the Plan and Benefit template.

- Streamline the Prescription Drug template to only capture the drug list, which can then be tied to each plan ID in the Plan and Benefit template.
- Provide an indicator that allows a drug to be labeled as covered under medical benefits.
- Improve the drug list count tool. We suggest working with Pharmaceutical Care Management Association to improve the functionality of that tool.
- Examine gaps in Rx CUIs.

Attestation/Justification Templates:
- These templates were difficult to use. It was hard to enter data and save the form, which caused issuers to have to print and scan into a PDF in order to upload into HIOS.
- Would be helpful if the form could be fillable PDF.

Business Rules Template:
- Questions on this template should be consistent with statutory and regulatory requirements. For example, we understand that the templates were finalized prior to the Market Rules, which resulted in some questions on the template that were inconsistent with or made unnecessary by that final rule (e.g., related to smoking and maximum dependent age). The answer to the question, "How is age determined for rating and eligibility purposes?" is already prescribed as "Age on effective date," so this question should be removed.
- The instructions for this template should be updated to make them clearer and minimize the need for revisions and resubmissions. Specifically, dependent type definitions need to be clearer. For example, an issuer may not have identified a spouse as a dependent, assuming that spouse was considered a dependent, but it did not appear that way in Plan Preview.
- More explicit and clear dependent relationships need to be added for the question, "What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as primary subscriber?" There was too much guesswork around this question for the 2014 submission, including lack of court-appointed dependent as an option and the use of "ward" to indicate "over-aged disabled dependents."
- Plan Finder should conform to the same business rules.

Dental:
- SADPs and the Plan and Benefit template are not really suited for dental benefits. The templates were adjusted somewhat for dental but were simply not built for dental plans and were more aligned with medical requirements. This caused continuing difficulties when trying to adapt them for dental plans. Having separate qualified SADP applications and separate QHP applications may avoid a lot of confusion regarding specific requirements for templates. It would also increase transparency when reopening and modifying the applications. Examples of inconsistencies include:
    - The only services pre-filled for dental were the exam, basic, major and accidental for child and adult, and insurers had to enter custom detailed services.
    - The dental plan templates in some cases refer to the deductible as the "medical deductible."
- Create a dental-specific Rate template as pediatric ages are different for dental.
- Recommend a unique dental Business Rules template. Medical and dental should be represented by two Business Rules templates, uploaded separately.
- Dental business rules need to accommodate rating more than three dependents. Currently, the template only has a category of "3 and above."
- If CMS continues to allow estimated dental rates, we suggest coordinating the processing of those rates with the Center for Consumer Information and Insurance Oversight (CCIIO) enrollment team. There still is not a way to process estimated dental rates.

- With regard to the timeline, submission of the dental application should be moved up so that is the same time as medical submission. More time was required for the dental submission than anticipated, so starting earlier will be helpful.

Rate Template:
- Change the tobacco validations to allow for sliding tobacco rating, as permitted under Affordable Care Act rating rules.
- Remove all non-validation macros, including those that hide, unhide, and populate data on the template. These macros make it more difficult for carriers to automatically populate the sheet with data from plan rate systems.
- Enable easier copy and paste functionality.

Plans and Benefits Template:

Functionality
- Overall, the template had too many password-protected fields. Issuers should have more allowance to delete and add fields, highlight, etc.
- Suggest enabling better editing and copy and paste functionality; perhaps simplify the macros (makes template population more difficult) within the template.
- It should be made easier to add or delete a benefit without requiring a full redo of the cost share tab. When working with state departments of insurance, plans had to make many changes to their benefits, which then required starting over on the templates. Suggest adding a “Delete Benefit” button similar to the “Add Benefit” button that will reflect the update when the cost share variance is refreshed.
- Template finalization/validation should check for the same things the HIOS system is looking for. We validated and finalized templates that then failed on the upload. We would prefer that they fail when we are finalizing the template so we can correct prior to upload.
- Simplify the template so it doesn’t require the use of the add-in template (e.g., create like the other SERFF templates that users can open directly and populate). The add-in made the template cumbersome to use, and sometimes it wouldn’t open properly with the add-in.
- The template, particularly the Cost Variance Worksheets, is difficult to review or allow a quality assurance check due to the lengthy horizontal format and that fact that it can’t be printed. It would be helpful to have a “quality assurance check” button on the add-in ribbon that could extract the data into an Excel document that facilitates plan-by-plan review by consolidating information found on the Benefit Package and Cost Variance Sheet in a more vertical, easy-to-read format. That way, any errors might be more readily identified. Some state exchanges, such as California, used this method before finalizing plan details on the Exchange.
- It would be helpful to tie drop-down menus in the Cost Variance Sheet to details entered in the Benefit Package. For example, if a benefit is identified as “yes, subject to deductible,” the drop-down choices for that benefit on the Cost Variance Sheet should be “$x after deductible” or “X% after deductible.” That would minimize discrepancies between the Benefit Package and the Cost Variance Sheet, and help in reaching the correct AV.
- Would like the AV in the Plan and Benefit template to match exactly to the one we get in the AV calculator, but I'm not sure how this is possible for plans like we have in one of our states since they only allow one cost share to be included for each benefit. The only way this would work for our plans is by allowing at least two cost shares (for example, two copays) to be entered for each benefit and then allowing the issuer to specify the utilization weighting for each one.

- In the State of Hawaii, transmission of information from this template to the Connector is an issue. A lot of other information was included on the Benefit Package tab (e.g., benefit limitations), and none of that information was transferred to Connector for a member to see when choosing a plan. Would like to see that gap closed.

Plan Information

- Grouping the plans into appropriate benefit packages is a big effort, and could be a lot more straightforward.
- Would like the ability to represent Indemnity and HMO plans correctly in the template. For example, indemnity plans do not have in-network or out-of-network benefits and HMOs have in-network only. Currently, have to add values just to get the template to validate.
- Would like to be able to name the silver plan variations (including AI/AN plans) differently than the base name.

Benefit Information

- Would like a description of each benefit. For example, some states associate the Rehabilitation benefit with OT/PT/ST, while others think it refers to Substance Abuse Rehabilitation.
- Suggest that CMS address an inconsistency in the Plan and Benefit template for how inpatient coverage is handled by type of benefit. For example, there were options for copayment per day for inpatient hospitalization which were not available for maternity or chemical dependency/mental health. Suggest CMS amend this.
- Suggest CMS revise the Plan and Benefit template so it doesn't populate with benefits that aren't true EHBs and/or accurately accounts for state mandates, and so it allows the ability to delete the first tab in the template in order to withdraw a plan. In the current version, if the first tab is deleted, an error message shows when uploading.
- With the SBCs, there was one overall link for each plan level, but it didn't get to the details of the CSR plans and the benefit differences and how the SBCs would be different from those.
- Benefit description should also address benefits that are covered based on place of service. Would like to understand which benefit to display consistently across all plans (e.g., most common, worst case scenario).
- For multi-tier benefits, allowing issuers to identify which benefits are in more than one tier would communicate benefits more clearly to consumers. The template currently allows cost sharing for more than one tier for those benefits, but does not support entering multiple tiers for all other benefits.
- Other suggested benefit changes:
  - Splitting prenatal and postnatal care.
  - Eliminating items that are "diagnosis" versus services, where multiple cost sharing based upon place and type of service come into play.
- Full range of options for quantity limit types: We suggest changing the benefits that are displaying on healthcare.gov. Not all of them seem to be top of mind for consumers (e.g. hearing aids, bariatric surgery, and acupuncture).

General Information

- EHB and state mandates were not always accurate, and there were inconsistencies between templates and benchmark plan policy documents. These should be confirmed with the state department of insurance before finalizing the state add-in file or allow for edits.
- EHB variance reasons in the Benefits Package tab should be cleaned up and with more detailed instructions on the use of the field, including what each variance reason means and when it should be used. It was difficult to tell which reason made the most sense.

- It would be helpful to have the ability to tie SBC URLs to all plans (i.e., silver plan variations), not just base plans.

Deductible and Out-of-Pocket Expenses
- The templates are not set up for individual deductibles. For carriers that may not establish a family deductible, members are directed to the benefit summary rather than seeing the deductible on the web site, causing potential confusion for consumers regarding the plan benefits.

Cost-Share Variance (CSV) Tabs:

Functionality
- The CSV tabs were very restrictive; if benefits were added or changed from “covered” to “not covered” or vice versa, in order for that change to display on the tab, the user needed to restart the whole tab, which in correction window timeframes made it difficult to avoid changing other data elements inadvertently during the copy paste process of creating the tab version.
- “Inpatient hospital per day after deductible” didn’t reflect correctly on the CSV tab, and this caused confusion on the Connector in the State of Hawaii, which didn’t pull information from both tabs. We entered on the Benefit Package tab correctly, but it did not provide the correct option in drop down menu to identify “copay per day.” Believe it’s still an issue today from the Connector standpoint.

Cost Sharing
- It would be helpful in both the AV calculator and Plan and Benefit template to be able to enter a copay amount for Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services instead of just a coinsurance.
- Suggest CMS add a “not applicable” field in the Plan and Benefit template for cost share items that don’t apply, as opposed to adding “no charge” or “$0” (e.g., cost share that doesn’t apply for a specific benefit).
- To simplify the CSV tab, could we identify each benefit as copay, coinsurance, or both so the tab only asks for data in the appropriate field (i.e., copay, coinsurance, or both)?
- The drop-down box for cost sharing should allow an issuer to indicate “Not applicable” or “Not covered.”
    - “Not applicable” will allow issuers to list a copay as such if it is a coinsurance benefit and vice versa. “No charge” and “$0/0%” are very confusing.
    - “Not covered” will allow issuers to indicate that a benefit is not covered instead of populating 100% coinsurance and “No charge” for copay (e.g., for benefits that are not covered out-of-network).
- In the Rx sections, we need more flexibility to display benefits beyond Copay/Coinsurance. Many benefits are a hybrid of the two.
- Would like the ability to display a maximum dollar amount for Rx (i.e., 50% coinsurance up to a maximum of $500.)
- The AV value field requires formatting with a “%”. If you enter as a decimal, the template validation passes, but when entered into SERFF, it errors out. This results in entering what issuers may consider incorrect values for in- and out-of-network respectively. Correct areas should be grayed out.
- It would be good if there was a question asking if non-emergency care was covered out of network. If the answer was “no,” the template would then not require populating 100% coinsurance and “no charge” on all the out-of-network benefits.

- Regarding cost share variance, add the ability to have "copay per day after deductible," which is especially important for the Hospital Inpatient benefit. The template currently does not have this capability.
- Regarding cost share variance, add the ability to have combination cost share options—for example, dollar coverage (at a copay/coinsurance/no charge/not covered) up to a certain dollar amount, then the option of copay/coinsurance/no charge/not covered. The template currently does not have this capability.
- The embedded AV calculator should determine the exact same AV as the stand-alone version. It does not always calculate the same value today (e.g., usually very close, but not exactly the same).

Unified Rate Review Template (URRT):

- Suggest enabling better editing and copy and paste functionality, and perhaps simplify the macros (makes templates population more difficult) within the template.
- Add in demographic adjustments as an input. Currently, it is impossible to directly compare rate levels on the URRT between carriers and plans without this information, as there are different underlying age assumptions.
- Loosen the strict validation requirements. Being off by less than a cent in certain fields produces validation errors. Check for too restrictive validation limits for factors that should not be restricted, such as: If morbidity is < 1.00; it does not validate, but it should.
- Add in the ability to easily delete plans.
- Suggest adding a cell to compute an industry-standard comparable rate level to promote competitor analysis.

Issues Specific to Filing in States Where CMS Was Responsible for ACA Compliance:

- If carriers missed the single training session, there were no further attempts to explain the process for filings to CMS in these states.
- The process of disapproval and comments was all done verbally through telephone calls from CMS; nothing was received in writing from CMS. Having something in writing would have been beneficial, with examples to illustrate and documentation on reasoning as well, as a few state departments of insurance asked for written direction from CMS once we re-filed changes with the states. Plans did not have anything to send.
- In most cases, there was only a five-business-day turnaround for redoing or providing forms, which often included SBCs that were in process of just being created. More lead time would be helpful in the future if planning can allow for it.

Suggested Related Rate and Benefits Information System (RBIS) Process Improvements:
Context: CMS announced it plans to create a new QHP template that can be used for both the Web Portal submissions and the 2015 SERFF submission in June. It would be helpful if issuers could use the same template for both activities. New RBIS templates will be based on the Benefits, Rates, Business Rules and Regions/Service area QHP templates, and it will be helpful if CMS is able to remove redundant or unnecessary fields and make more user friendly.

- Ensure that the new QHP templates can work in place of submitting RBIS templates.
- Suggest allowing issuers to submit a URL link and or a PDF file instead of the U.S. Department of Health and Human Services (HHS) composing a pre-enrollment SBC from the Plan and Benefit template elements.
- Allow for medical loss ratio in the new Rate template. One template for both submissions would be optimal.
- Ensure that the Business Rules template will work in the post-ACA environment.

- In the future Plan and Benefit template, suggest removing the mandatory verbiage requirement of “Copayments, Premiums, and Balanced Billing” in the “Excluded Annual Out of Pocket Limit.”
- In the PCP Out-of-Pocket Copay, allow “N/A” instead of “0” or “none.”
- Suggest building in more flexibility for phone contacts; allow for more than one phone number.
- Suggest including more flexibility with URLs.
- For Small Group, Oregon has a waiver to allow composite rates. To ensure consistency, suggest issuers should be able to allow for state variation and requirements.
- Would be helpful to provide a record or for issuers be able to download all submitted HIOS, component, and variant IDs with the plan name.