BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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December 31, 2013

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10433
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Re: **Comments on Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (CMS-10433)**

Dear Sir/Madam:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services ("CMS") proposed information collection supporting the Qualified Health Plan ("QHP") certification and other financial management and Exchange operations [CMS-10433] released by CMS on November 1, 2013.

BCBSA is a national federation of 37 independent, community-based, and locally-operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health coverage for 100 million –one in three- Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, and the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

We support CMS efforts to ensure information on QHP options is clearly and accurately displayed to consumers on exchange websites. Over the past year, Plans have worked closely with CMS to clarify information shared via webinars, slides and Q&As for filling out plan management templates. Many Plans provided dedicated resources to CMS to establish template functionality, workarounds, and ensure data was validated. We are committed to continuing to work closely with CMS to apply lessons learned from 2014 and ensure a smooth and efficient plan certification process for the 2015 plan year and beyond.

BCBSA appreciates CMS issuing information on the proposed data collection for certification of qualified health plans ("QHPs"). The detailed health plan certification and

requirements addressed in the PRA are interwoven with the rules issued by CMS which impact virtually every major function carried out by Plans.

Given the very short timeframes for completing all federal and state regulatory processes to be ready for open enrollment in 2015, BCBSA recommends streamlining requirements by ensuring effective automation of critical submissions and providing sufficient time between finalizing requirements and QHP application deadlines.

BCBSA offers the following major recommendations:

1. **CMS should provide sufficient time for testing of the templates to ensure data accuracy after the release of final requirements, instructions, and guidance.**

   It is critical that CMS allow for an adequate level of testing to ensure the accuracy of information for certification and for Plan Compare display prior to the application window opening and prior to Plan Preview.

   During the last plan certification window, CMS was forced to issue a number of updates for the templates during the data submission window due to unforeseen errors with the templates. Plans that submitted data early were penalized for their early submission by having to resubmit data in response to the template updates. The most critical timeframe for issuers is the span of time between when requirements for QHPs are finalized, and when applications are due to exchanges which may or may not align with deadlines for filing rates and products with states. While the Preamble of the Proposed Notice of Benefit and Payment Parameters suggests that exchanges would delay their certification dates by a month if the annual enrollment period is changed, state deadlines for products and rates could significantly precede the exchange application deadline. Therefore, we strongly urge CMS to finalize all requirements as soon as possible to ensure issuers have sufficient time before filing products and applying for certification.

   Specifically, BCBSA recommends that CMS release final requirements, instructions, and templates 2 months prior to the opening of Plan certification submission window. Plans need certainty regarding the templates and the submission process in order to prepare for offering plans on the exchange.

   During the last plan certification window, the use of standardized scenarios in “plan preview” verification also limited the ability of CMS and Plans to adequately test the templates. Rather than providing standardized testing scenarios, CMS should allow Plans to create their own testing scenarios and allow 4 months for the testing and verification of templates prior to the opening of the plan certification submission window. This will mitigate the need for subsequent data changes, and alleviate validation problems that Plans encountered during the application window last April.

   Additionally, to ensure broad testing within plans, issuers should be allowed to use an entity code, rather than a personal social security number, for testing during plan preview.

2. **CMS should eliminate duplicative data collections by leveraging existing data sources to the greatest extent possible and clarify intended use of required data.**

CMS requests redundant information in plan certification templates, premium stabilization program data collections, and other HIOS filings. CMS should streamline the collection of information by requiring information to be submitted only once.

The amount of data requested by CMS in the proposed data collection imposes a significant burden on Plans. During the 2014 plan certification process, Plans undertook a massive effort to complete and submit the templates to CMS, as well as address a wide variety of data validation and display issues.

BCBSA recommends CMS avoid unnecessary burden, especially when some of the data could be obtained from other existing data collections. BCBSA recommends that CMS provide a crosswalk that will highlight the interdependencies between the various templates and how CMS will utilize the data, including how information will be displayed on healthcare.gov. CMS should also rely on the use of attestations to reduce the burden on Plans.

3. CMS should coordinate with states and plans to ensure the proper pre-population of essential health benefits (EHB).

During the last plan application process, Plans found that EHB data did not properly pre-populate when the templates were released. Without adequate clarification from CMS on what benefits met the state specific benchmarks, plans were forced to rely on their own interpretation. BCBSA recommends that CMS provide for extensive testing of the auto-populated EHB data in the plan and benefits template as well as the AV calculator prior to the opening of the submission window.

4. CMS should provide additional training and detailed instructions to minimize the number of errors during the template submission process

Avoiding errors will be critical to ensuring products are approved, certified, and available to consumers on exchanges. These materials should clearly specify known issues and workarounds identified in testing to minimize errors and reduce the burden for issuers. It will also reduce the burden on CMS by decreasing a Plan's need to contact the CMS help desk. Ensuring issuers can preview, verify, and easily address issues with Plan information before it is provided to consumers will be critical.

5. CMS should ensure Plans can use automated processes to populate information into the templates and revamp the template validation process.

CMS proposes to continue with the time and labor-intensive process used during 2014 Plan certification. As this process primarily relied on manual data entry, it was prone to errors. BCBSA recommends that CMS allow plans to automate completion of the templates, including allowing plans to submit XML files generated in a ready to submit format from Plan databases. It is critical that health plans are permitted to automate these templates as Plans will need to complete the templates for a large volume of QHPs. The use of automated processes will help to mitigate the potential for data entry errors.

CMS should also provide clarity on the version of the software used to develop the templates. Last year, plans encountered issues with entering information into the

templates due to software version issues, including preventing the proper operation of macros. BCBSA recommends that CMS be explicit about the proper file type and the exact version of the software used to develop the template.

Data validation is critically important to ensuring that templates are filled out with the correct data. There were inconsistencies between how the data in SERFF and the templates was validated. Therefore, BCBSA recommends that the HIOS template validation process be aligned with SERFF validation. Additionally, if errors were found after the validation process, plans were forced to create workarounds because individual fields were locked after validation. BCBSA recommends that CMS prevent the locking of fields prior to the close of the submission window so that Plans can make targeted corrections and avoid using confusing workarounds.

After completing successful validation, Plans found that templates sometimes failed to upload into HIOS. BCBSA recommends that CMS implement a system of checks that would ensure that a template will upload if it meets the checks.

CMS should also provide more clarity on how the templates are uploaded to CMS systems and whether separate templates can be submitted for the individual market and the SHOP. Last year, Plan data appeared to be accepted based on how Plans submitted the data. Issues arose when plans would upload individual market data followed by a template with SHOP data. The second upload would overwrite the individual market data, leading to extra burden and increased Plan frustration. Therefore, BCBSA recommends CMS clarify how data is uploaded to CMS systems including providing clarity on whether CMS's expectation will be for Plans to submit individual market and SHOP data in the same template or on different templates.

In addition to clarifying the initial upload process, it is important that CMS clarify how plans can update data on the various templates after initial submission to CMS. Some instances in which Plans may need to update data include:

- Prescription drug coverage data: Over the course of the year, the data may change due to the availability of drugs, including the introduction of new drugs and the removal of drugs from the market.
- Organizational chart: Submitted as part of the administrative data collection, it is subject to change with the evolving structures of the Plans.

6. CMS should create templates specifically for stand-alone dental plan data.

BCBSA appreciates CMS's effort to improve upon the collection of data for stand-alone dental plans (SADP). However, the templates, designed primarily for health plan data, are not properly built for the SADPs. BCBSA recommends that CMS develop separate templates tailored for SADP certification data collection, specifically templates for essential community providers, plan and benefits, and rating tables.

For example, CMS built the rating table template for health plans with variables different from SADPs. The template only provides for age bands of 0-20 with individual ages thereafter. This creates difficulty when entering SADP rates, due to the maximum age of pediatric dental being 18 years old. Plans face issues when entering rates for ages 19 and 20. This forces Plans to specify rates for ages 19 and 20 as estimated rather than guaranteed.

7. CMS should provide more clarification for states and promote consistent state requirements and processes

Issuers that offer plans in multiple states had difficulties meeting the deadlines for the various QHP application windows in 2014. BCBSA acknowledges that each state based exchange has the flexibility to develop requirements and processes tailored to the needs of the state. However, increased alignment of the state based exchanges processes with the federal processes will reduce the burden on issuers and create administrative efficiencies that will benefit both the state based exchanges and CMS. Aligning the processes will allow state-based exchanges and CMS share best practices and learn from the issues that may arise in other exchanges.

BCBSA recommends that CMS provide additional clarification on which requirements and data elements are open for interpretation by state DOIs. During the 2014 Plan certification process, states interpreted federal requirements in a way that created inconsistencies between states. The burden on issuers to meet the wide range of state requirements added to the already overwhelming burden faced by issuers developing products and completing template submission under tight timeframes.

8. CMS should defer to states on network adequacy and Plans for providing information to consumers on provider networks.

CMS proposes to collect provider files from Plans and the "Supporting Statement" provides very little detail beyond specifying that the information would include provider names, counties, and types. If CMS's intention is to utilize the information to assess network adequacy, HHS should, given the ACA's deference to state regulatory authority, continue to defer to the states to set standards and assess whether plans meet those standards. For certain states that do not have a sufficient network adequacy process, it would make sense to collect the provider file. However, we recommend that CMS avoid requiring all Plans to submit a provider file.

If it is CMS's intent to use the provider file to display information for consumers, CMS already proposes to collect URLs to Plan provider directories. Additionally, CMS would be placing unnecessary burden on Plans to frequently update provider information. Making this information available through an exchange would require physicians to update information to Plans on whether they are accepting new patients and would include administrative delays that could confuse consumers. Delays in reporting and updating systems with the relevant physician information could result in individuals making misinformed decisions about a provider's availability to accept new patients.

Further, without additional information, including the purpose of the data collection, process for assessing the data, and the collection timeline, BCBSA is concerned that CMS has not provided Plans with an adequate opportunity to comment on the collection and the burden it may cause. As such, BCBSA recommends that CMS not include the provider file in the final information collection request.

9. CMS should clarify when changes are made to existing regulatory documents stored in REGTAP.

BCBCA appreciates the efforts of CMS to disseminate information to Plans in a timely and organized manner. Recently, CMS announced changes to the distribution of information through REGTAP, including consolidating the FAQs into a searchable database. BCBSA asks that CMS continue to distribute the following information through REGTAP:

- Clearly indicate when a previously published Q&A posted in CMS FAQ documents has been modified.
- New frequently asked question documents, including a full, separate set of newly issued Q&As in a separate document.

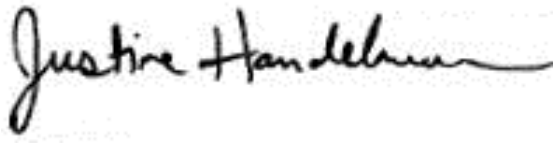
It is vital that Plans have the most up-to-date and comprehensive information regarding policy criteria to avoid confusion and the potential for errors.

* * *

Our detailed comments on the proposed information collections are below.

We appreciate your consideration of our comments. We look forward to continuing to work with CMS on issues related to the Affordable Care Act. For questions, please contact Jerod Brown at (202) 626-4819 or jerod.brown@bcbsa.com.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross Blue Shield Association

Cc: Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, Department of Health and Human Services

BCBSA Detailed Recommendations on Plan Data Collection to Support QHP Certification and Other Financial Management and Exchange Operations

The following comments are provided in the order of CMS documents released within the PRA Notice, "Initial Plan Data Collection to Support QHP Certification and other Financial and Exchange Operations," [CMS-10433].

General Comments

Issue #1: During 2014 Plan certification, Plans had to manually enter the same data into different templates.

Recommendation: BCBSA recommends that CMS improve the template copy and paste functionality to reduce the need to manually enter information into the templates

Rationale: Improved functionality will reduce the time and effort burden for Plans. This will provide Plans with the opportunity to use their resources to ensure data accuracy and address potential template and submission issues.

Appendix A: Issuer Application Data

Administrative Data (A.1)

Issue #1: The data from this template seems to be a duplicative data collection given that data is collected through other data collections.

Recommendation: BCBSA recommends that CMS consider making the Administrative Data template optional or eliminating the template completely.

Rationale: Much of the data that is being collected through the Administrative Data template can be accessed through other sources. It is an unnecessary burden on Plans to have to fill out the template if the data is collected elsewhere and the data is not used to populate healthcare.gov.

Issue #2: While Plans submitted customer service numbers through administrative template, CMS pulled customer services numbers from HIOS. This led to the incorrect customer service numbers being displayed for consumers.

Recommendation: Provide more clarification as to who is using the data and how they are using it, including whether data is being used to populate healthcare.gov.

Rationale: Plans need to know how the data is being used so that they can tailor the data submission. For example, CMS seemed to pull customer service numbers from HIOS for healthcare.gov. However, Plans submitted different customer service numbers in the templates since the template numbers were meant for Exchange specific products.

Issue #3: Due to the administrative template and Plan filings requiring different information for Plan marketing name, the inappropriate name was used for display on healthcare.gov.

Recommendation: BCBSA recommends that CMS clarify the source of the data they intend to display to the consumers and how they intend to display the data.

Rationale: Clarification regarding which data source CMS intends to use for consumer display will prevent the incorrect data, including using the legal name or the marketing name for the Plan, from being displayed to the consumer.

Issue #4: It is unclear how information can be updated in the template after initial collection.

Recommendation: CMS should clarify how Plans may update information in the template after initial submission.

Rationale: If the data is used for display on the healthcare.gov, Plans want to make sure that CMS is using accurate and up-to-date information. For example, Plans found that organizational charts changed throughout this past year and as such the information submitted to CMS during the submission window was inaccurate soon after submission.

Essential Community Providers (A.2)

Issue #1: While the template has NPI and TIN fields, the list of ECPs released by CMS last Plan certification cycle did not provide the NPI or TIN for providers. In order to validate the data in the template, Plans had to crosswalk the data using the addresses of the essential community providers.

Recommendation: CMS should provide NPIs and TINs in the list of ECPs and whether ECPs are able to contract with Plans.

Rationale: The addresses in CMS's list of ECPs were not entirely accurate. Changing provider addresses created data validation issues. By providing the NPIs and TINs in the list of ECPs, CMS would decrease the burden on a Plan by allowing a Plan to more accurately crosswalk the Plan's template data with the ECP list. It would also allow for more efficient compliance checks after the initial submission. Providing information about whether an ECP is able to contact is important as no all ECPs met standards for participation in 2014.

Issue #2: There are situations in which a Plan contracts with individual provider within a group, rather than the entire provider group. It is unclear from looking at the template whether a Plan can list an entire ECP entity or an individual provider from an entity.

Recommendation 2: BCBSA recommends CMS provide more clarity on how to handle situations in which Plans contract with individual entities, rather than an entire group.

Rationale: Since Plans sometimes contract with select individuals within a group, it would be inaccurate and misleading to consumer to list the entire group as an ECP included under the Plan**.**

Issue #3: The list of essential community providers released by CMS did not include entirely correct addresses.

Recommendation: BCBSA recommends that CMS update federal lists of essential community providers to reflect current addresses. Updates for the addresses should be issued on a regular basis so that Plans can anticipate when updates will be released by CMS.

Rationale: Not all federal lists had the correct address for professional groups. Without the correct address or NPIs/TINs, Plans fail to show a matching provider, and were unable to validate the ECP template data.

Network ID (A.4)

Issue #1: CMS does not specify the format of the URLs to be entered into the network ID template.

Recommendation: CMS should clarify the specific format of the URLs that are required to be entered in the template.

Rationale: Last year, CMS did not provide the specific format of the URLs. Some Plans entered only the core of the URL, without providing "http://" or "https://." This led to non-functioning links being displayed on healthcare.gov.

Appendix B: Benefit and Service Area Data

Plan and Benefits (B.1)

Issue #1: Issuers are required to enter "No charge" in the copayment field or 100% coinsurance in the coinsurance field when a Plan does not cover a benefit.

Recommendation: CMS should modify the Cost Sharing Variance worksheet to include "Not Covered" as an option for the cost-sharing amount.

Rationale: Plans who reported no charge or 100% coinsurance found that information displayed on Plan Compare. It is misleading for consumers to display no charge or 100% coinsurance. This is evident by the fact that Plans have been receiving consumer and producer inquiries asking for an explanation of the no charge or 100% coinsurance.

Issue #2: Template creates confusion and increased burden by requiring issuers to populate 100% coinsurance or "no-charge" on all benefits not covered by the Plan.

Recommendation: BCBSA recommends adding a "not covered" option to the drop down menus in the cost sharing variance tab for all co-pay and coinsurance. Template should ask whether non-emergency care is covered out of network. If the Plan specifies that non-emergency care is not covered out of network is not covered, then the remainder of the fields should be blocked.

Rationale: By entering 100% coinsurance or no charge, this was displayed in Plan Compare in a way that creates consumer confusion.

Issue #3: If the Plan changed a benefit package, the Plan needed to recreate the cost sharing variances tab in its entirety and re-enter all the details for each variant.

Recommendation: Allow issuer to add or delete a benefit without having to redo the entire cost sharing variance tab from the beginning. CMS should create a copy Plan feature in the template that would significantly reduce the burden of having to recreate tabs.

Rationale: Will decrease the burden on Plans to manually enter data

Issue #4: Multiple In Network Tiers data is collected at the Plan level, not the benefit level. However, the drop down menus for cost-sharing includes "No In-Network Tier Two" which may be an attempt to solve the issue. The Plan Compare display will be misleading unless selecting that value means the Tier Two value will not display.

Recommendation: BCBSA recommends that CMS suppress fields with the "No In-Network Tier Two" value.

Rationale: Due to the limited nature of the text display on Plan Compare, this value creates unnecessary clutter on Plan Compare.

Issue #5: In the previous Plan certification cycle, an issuer needed to completely recreate a tab if the issuer created a new Plan that was almost identical to another Plan except for network.

Recommendation: BCBSA recommends that CMS permit issuers to duplicate benefit packages in a way that would maintain functionality of the macros.

Rationale: The functionality would reduce the burden on issuers by mitigating the need for duplicative and error-prone manual data entry.

Issue #6: The template requires a plan to submit URLs specific to cost sharing variations without providing Plans with the option to provide a top-level URL.

Recommendation: BCBSA recommends that CMS provide Plans with the flexibility to choose whether to provide either top-level, centralized URLs or Plan specific URLs for the plan brochure, Summary of Benefits and Coverage (SBC), provider directory, pharmacy, and payment redirect.

Rationale: Issuers may want to provide this data once for all plans (e.g. if all the issuer's plans use the same formulary) or for each plan separately (e.g. if an issuer has separate brochures for each plan). Allowing issuers to provide one for all plans will decrease burden and duplicate work.

Issue #7: In the past, the lack of a separate SADP template, rather than a repurposed Plan and Benefit template, led to inaccurate information. Multiple fields in the Plan and Benefits template were not applicable to stand-alone dental.

Recommendation: CMS should create a separate SADP template that contains only SADP specific fields and that would apply SADP specific rules.

Rationale: The surplus fields created confusion for SADP issuers. For example, SADP issuers entered information for the SBC URL that did not display because SADP issuers are not required to create SBCs.

Issue #8: The Benefits tab forces a plan to select tier 2 for a benefit when there may not be a tier 2. Plan Compare shows that there is a tier 2 for a benefit package, which seems to be connected to how data is entered into the Plan and Benefits template.

Recommendation: BCBSA recommends that CMS modify the Plan and Benefits template to permit tiering at the benefit level, rather than displaying all the benefits as tiered if tiering is selected at the Plan level. If CMS intends to continue with having tiering at the Plan level, BCBSA recommends that CMS program the Plan Compare to suppress template data for the second tier if a Plan demonstrates there is only one tier for a benefit.

Rationale: It is misleading and confusing for the consumer to display a second tier for a benefit when a second tier does not exist.

Issue #9: Last year, Plans encountered issues with the auto-population of state specific benchmarks for essential health benefits.

Recommendation: BCBSA recommends that CMS provide for extensive testing of the auto-populated EHB data in the Plan and benefits template, as well as the AV calculator, prior to the opening of the submission window.

Rationale: The correct auto-population of EHB data is critical to Plans. Testing will allow Plans to ensure the correct auto-population of the EHB data.

Issue #10: The auto-population function in the Plan and Benefits template created misleading information in the template, including generating HSA plans despite the plan not meeting QHP standards.

Recommendation: BCBSA recommends that CMS allow Plans to create only the cost sharing variation for American Indians and Alaskan Natives (AI/AN) under 300% of the federal poverty level (FPL) at the Bronze level when there is no difference in covered services or network. CMS should also allow Plans to not generate HSA plans when they do not meet QHP standards.

Rationale: Creating the additional metallic levels is misleading as the plans would provide the same coverage as the Bronze level. As for the HSA plans, issuers in the past had to try to get the FFM to indicate that the HSA plan did not meet standards. Both issues create enrollee confusion that leads to an added burden on Issuers to perform additional enrollee outreach.

Issue #11: During the last certification cycle, Plans were forced to interpret what benefits were appropriate to meet the state specific benchmarks when EHB failed to auto-populate. This led to a wide variety of interpretations with some Plans taking a minimalist benchmark interpretation.

Recommendation: BCBSA recommends that CMS provide more clarity on the allowed variances in the state specific benchmark EHB prior to the release of the final templates. The template should be cross-validated with States to determine whether a Plan is using an allowable variance.

Rationale: By providing more clarity on the allowed variances for EHB and cross validating with States, CMS will help to ensure that Plan coverage of EHB will be more uniform. Last year, some state regulators looked to impose allowable variances after Plan certification thereby creating additional burden on issuers. Cross validation with states will prevent this unnecessary burden on Plans.

Issue #12: Template creates an unnecessary burden on Plans to populate 100% coinsurance or no-charge on all out-of-network benefits when non-emergency care is not covered out-of-network.

Recommendation: BCBSA recommends that CMS amend the template to ask whether non-emergency care is covered out-of-network. If the Plan does not cover the benefit out-of-network, the Plan should be able to enter not covered and not be required to continue to populate with 100% coinsurance or no-charge.

Rationale: This will reduce the burden on Plans to manually enter unnecessary data into the template.

Issue #13: Adding the AV Calculator Additional Benefit Design fields to the Cost-Sharing Variance worksheet is problematic because the fields are linked to a single benefit. For example, inpatient copay max is tied to inpatient hospital but not inpatient mental health.

Recommendation: CMS should modify the AV calculator so that results can be saved and submitted separately from the Plan and Benefits template. This would allow CMS to streamline the Plan and Benefits template to only include the fields that are required for Plan Compare.

Rationale: Last year, issuers were required to take AV calculator screenshots to demonstrate that certain plans met the requisite actuarial value due to template validation errors. Adding functionality to save and submit AV calculator results separate from the submission of the Plan and Benefits template would eliminate the need for screen shots and reduce the error potential for issuers. It will also ensure consistency when expanding the AV calculator and allow CMS to streamline the Plan and Benefits template for Plan Compare.

Prescription Drug (B.2)

Issue #1: Template does not allow Plans to accurately specify the tiers for prescription drugs. The generic drugs and specialty drugs columns only allow for a single tier of benefits to be listed.

Recommendation: CMS should provide Plans with a method for identifying tiers of drugs beyond all brand name or only generic. Furthermore, BCBSA recommends against using the term “all” and instead using the term “only,”

Rationale: It is inaccurate to label all Plans as either only brand or only generic. The inability to accurately label tiers for drugs led incorrect display of cost sharing for consumers. Some Plans may have tiers of generic drugs with varying coverage. It is misleading to the consumer to list all generic drugs as the same when they are not covered the same.

Issue #2: It is unclear how and when Plans can make changes to the prescription drug template.

Recommendation #3: BCBSA recommends that CMS should provide clarity on how Plans can make changes to the template and provide a crosswalk of drugs.

Rationale: CMS has stated that a Plan needs to submit changes only if the plan goes below the benchmark for prescription drug coverage. However, Plans will need to make formulary changes when new drugs are released or removed from the market.

Issue #3: Currently, there is not a good crosswalk for the RxCUI system making it hard to determine what drugs can be added or deleted without going through trial and error.

Recommendation: There should be a nationally published crosswalk to national drug codes (NDCs).

Rationale: Certain USP category and classes are vague and determining which drugs fall under these categories is challenging. Without a good RxCUI crosswalk, Plans have to go through trial and error to determine which drugs can be added or deleted.

Service Area (B.3)

Issue #1: There is a lack of information as to how the service area template impacts all other templates.

Recommendation: BCBSA recommends that CMS provide clarity on how the various templates interact and affect each other.

Rationale: Plans need to know how the templates interact before entering information. Without such information, the Plans will not be able efficiently plan for how and when to enter data into the templates.

Issue #2: The county field is a dropdown that Plans have to scroll through to select the county. For Plans with large numbers of counties, scrolling through the dropdown menu proved to be a burdensome process.
Recommendation #2: BCBSA recommends that the county field be set up for the user to start typing the county name and the template will automatically bring up the item form the list that matches.

Rationale: [Feedback sought by plans]

Appendix C: Rating Tables and Business Rules Data

Rate Table (C.1)

Issue #1: Tobacco rates will not display in the current version of the templates. It is unclear how the template loads rates for smokers.

Recommendation: BCBSA recommends that CMS clarify the data validation so that the smoker load can vary by age so that the full rate difference between 21 and 64 could be 4.5:1, which includes 3:1 for age and up to 1.5:1 for tobacco use.

Rationale: Plans received errors if rates with a smoker load varied from the 3:1 ratio between a 21 and 64 year old. Plans need the flexibility to vary the smoker load by age up to 1.5:1 so a 64 year old smoker could essentially be 4.5 times higher than a 21 year old.

Issue #2: The rating table template is not designed for standalone dental plans.

Recommendation: CMS should develop a separate template specific for standalone dental.

Rationale: The template only allowed issuers to enter a 0-20 rate, single age bands up to 64, and a 65+ rate. This meant that plans could not properly load rates for 19 and 20 year olds for dental Plans. Plans were forced to specify that rates were estimated, not guaranteed. This has a significant impact when displaying Plans for consumers.

Issue #3: The rating table template is built to tie the secondary subscriber and the dependent rates to the age of the subscriber, rather than the individual ages.

Recommendation: CMS should adjust the template to untie the secondary subscriber and dependent rates from the subscriber age and allow for rates to be tied to each individual's age.

Rationale: Plans calculate rate using a member-level build up approach. Under this approach, the rate for each member under a contract is identified and summed to determine the family rate. The proposed template does not accommodate this approach because the secondary subscriber and dependent rates are tied to the subscriber age.

Business Rules (C.2)

Issue #1: Last year, there were a number of workarounds created to temporarily address issues during the plan certification process. For example, the relationship code for ward was given two meanings, ward of the state or disabled dependent.

Recommendation: BCBSA recommends that CMS create distinct relationship codes to address the issues that arose last year and to reduce the potential for confusion derived from using codes to mean various things.

Rationale: Plans' business rules vary depending on the relationship and cannot apply two separate business rules for the same relationship code. For example, a Plan may not cover wards of the state but do cover disabled dependents. Even when both relationships are covered, an issuer may impose different rules for each, e.g. an issuer's eligibility criteria may require a disabled dependent over the age of 26 to be unmarried.

Issue #2: Last year, many Plans had to resubmit the Business Rules template because it was not clear how each product line was to be differentiated since the template shades the first two cells in the first row.

Recommendation: CMS should provide more clarity on how product lines are differentiated in the Business Rules template. If the cells have to be grayed out for a

particular reason, BCBSA recommends that CMS provide further instruction on how to fill out the Business Rules template given the grayed out cells.

Rationale: Additional instruction will reduce the need for Plans to resubmit the Business Rules template.

Appendix D: Transitional Reinsurance Program, Risk Adjustment Program, and Payment Operations Data Requirements

Issue #1: In this data collection, CMS appears to be asking for data that is already collected in other federal and state data collections. The duplicative data collections include information about off-exchange products for risk adjustment and reinsurance purposes.

Recommendation: BCBSA recommends that CMS streamline the data collection by eliminating duplicative collections and using data submitted through already existing data collections.

Rationale: CMS is already asking for the submission of similar data for the Plan certification process. Additionally, states already require the filing of both on and off exchange product information through SERFF. CMS is creating an unnecessary burden on issuers by asking for the information through this collection rather than relying on existing resources.