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Submitted electronically via: http://www.regulations.gov

Ms. Martique Jones
Deputy Director, Regulations Development Group
Office of Strategic Operations and Regulatory Affairs
Center for Medicare and Medicaid Services
Attention: CMS-10433
Room C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

Subject: Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (CMS-10433) – AHIP Comments

Dear Ms. Jones:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Information Request related to Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations for the 2015 coverage year, published in the *Federal Register* (78 FR 65656) on November 1, 2013, and the subsequent detailed information posted on the CMS Paperwork Reduction Act (PRA) website. AHIP is the national association representing health insurance plans that provide coverage to more than 200 million Americans.

AHIP worked collaboratively with CMS and issuers during the 2014 Qualified Health Plan (QHP) certification process and we are committed to providing the same support for the 2015 data collection and certification processes. The comments submitted in this letter reflect AHIP's two core goals for the QHP certification process in the Federally-facilitated Exchange (FFE) and State-partnership Exchanges (SPEs). First, we believe that lessons learned from the 2014 QHP application templates and submission can be applied to establish a more stable certification process for 2015 and subsequent plan years. Second, we are committed to establishing an approach to initial data collection, resubmission, and plan preview that ensures plan data is displayed in a manner that is meaningful and actionable for consumers.

Maximizing the Value and Efficiency of Data Collection

There are many important takeaways from the 2014 application submission that could vastly improve the data collection process for 2015 QHP certification. Moving forward, the goal for

template revisions should be to minimize changes from one year to the next so that issuers can automate their processes and improve the efficiency of data submission. However, to lay the groundwork for a more stable certification process in subsequent years, some templates will require substantial revisions for 2015 certification. We recommend that CMS leverage existing templates where feasible for those that require fewer changes in terms of structure and functionality. Other templates, such as the Plans and Benefits and Prescription Drug Templates require significant rework and may need to be largely rebuilt. Dedicating resources to optimize key templates for the 2015 submission will result in improved efficiencies and lower administrative costs in subsequent years. AHIP's detailed comments on each template are included in the appendix.

As a general note, we also recommend that CMS consider the value of the number of data elements required for submission. The 2014 QHP application asked issuers to provide a substantial number of data elements, yet a large volume of those data elements collected were not used by CMS as part of the certification nor displayed to consumers on Healthcare.gov. For example, over 35 data elements collected in the Plans and Benefits Template were not displayed in Plan Compare. Collecting this plan data and submitting templates required substantial issuer resources. We ask that CMS focus on collecting data elements that are necessary for certification purposes or to support consumer plan selection and enrollment, and streamline or eliminate superfluous data elements. In addition, we recommend that Plan Compare include prominent disclaimers to indicate that the "Plan Details" display is only a summary and more detailed coverage information can be found in the Summary of Benefits and Coverage.

In order to accurately submit QHP data to support certification and to be displayed on Plan Compare, issuers need to fully understand the purpose and requirements for each data element. A comprehensive data dictionary is critical to ensuring data elements are consistently defined and not subject to errors in interpretation. Specifically, we recommend that the data dictionary include a description of the desired data for each field, examples, formatting requirements, and limitations. Further, more comprehensive explanations of the underlying purpose for the data elements would support more accurate completion of templates. We also suggest that CMS highlight templates that have known interdependencies and will require crosswalks to accurately complete data entry. Providing a data dictionary and clarifying requirements for data elements will ensure that data is reported accurately and consistently in the initial data submission.

Finally, we agree that the certification process is critical to ensuring that consumers can easily view and compare plan information in a way that allows them to select the health plan that best meets their needs. Prior to finalizing templates, CMS should ensure that plan data from the QHP templates will meaningfully translate to Plan Compare. To that end, we emphasize the importance of aligning the full end-to-end data submission process is aligned with the consumer experience in Plan Compare. As CMS revises QHP templates, it should ensure that template submission requirements align with the Plan Compare display formatting to ensure plan

information is accurately displayed to consumers. It will also mitigate the need for data corrections during the Plan Preview window. In addition, it is critical that QHP data is displayed for issuer review during Plan Preview exactly as it will display to consumers in Plan Compare. Better insight into how submitted data will display to consumers will help issuer make more meaningful data corrections that are reflective of the consumer experience. Such an approach will ensure that key plan information impacting consumer decision-making such as benefits, cost sharing, and URLs display meaningfully to consumers

Establishing a Certification Timeline that Focuses on Data Integrity

Many of the challenges that issuers faced during the 2014 certification process were exaggerated by the tight timelines to enter data, submit templates, and verify their accuracy. The initial data collection was especially troublesome because templates were published after the start of the submission window and revised during that period. CMS also implemented manual workarounds for many fields so that templates could validate and upload. The late release and manual workarounds made it difficult for issuers to meet the submission deadline and resulted in plan data displaying incorrectly in Plan Preview, which required additional data corrections. While we do not anticipate the same level of challenges in subsequent certification periods as the first year of this program, it is critical that deadlines allow enough time to ensure that data is submitted and displayed accurately and consistently.

CMS has indicated in the preamble to the Notice of Benefit and Payment Parameters, published in the *Federal Register* on December 2, 2013, that it anticipates delaying the beginning of open enrollment for the 2015 coverage year by one month, which would subsequently delay QHP certification by one month (78 FR 72355). We support the delay of the opening of the QHP application submission window to May 1, 2014, to provide issuers additional time to assess 2014 QHP enrollments prior to setting rates for 2015 QHP submissions.

To ensure a smooth data submission process, ***templates must be finalized and tested prior to opening HIOS for the QHP application submission window.*** We recommend that final templates, instructions, data dictionary, validation macros, and an overview of the submission process and timeline for each type of filing (i.e., HIOS/SERFF and QHP/QDP) be ***published 45-60 days prior to the beginning of the submission window, or as soon as they are finalized if earlier.*** This will give issuers sufficient time to ensure they fully understand submission requirements, identify data sources, and finalize any systems coding to ensure accurate completion and validation of templates. It is especially important that all templates are fully tested prior to being published and that they are not revised after publication once the submission window opens. During the 2014 initial submission window, multiple template updates were released while applications were in progress using previous versions. This required significant rework for issuers to migrate data to the new templates. As issuers are being asked to control

costs more than ever, advance notice of the certification timeline and requirements is necessary to prepare for filings and allocate appropriate resources.

We also recommend that the certification timeline provide additional time for issuers to review data in Plan Preview and submit changes. Based on issuer experiences with the 2014 submission deadlines, we recommend that Plan Preview last for three weeks (15 business days) with scheduled weekly refreshes during the window. Modeling Plan Preview off of the Plan Finder refresh window will allow issuers to view data corrections to ensure that approved changes are accurately reflected. We also ask that CMS confirm which fixes or data changes are deployed with each refresh so issuers know specifically which data elements to test. Plan Preview should remain open as long as CMS continues to implement changes to ensure issuers can complete full end-to-end testing of plan data before it is locked down.

Current outstanding regulations will impact the open enrollment dates for the 2015 coverage year. We believe that a full end-to-end QHP certification timeline for 2015 plans cannot be established until the open enrollment dates are finalized. These recommendations related to the certification timeline represent AHIP's initial comments and we look forward to continuing to work with CMS to establish a schedule that gives issuers and CMS sufficient time to ensure that submitted data is correct and will be accurately displayed to consumers to support plan selection and enrollment.

Promoting Consistency across States

AHIP reiterates our previous comments related to variation in certification requirements across states for issuers who offer QHPs in multiple FFE and State-based Exchange (SBE) states. Many issuers offering QHPs across multiple states struggled with the various FFE and SBE submission requirements and deadlines and sometimes conflicting guidance. While SBEs have flexibility to establish their own requirements for the submission process, ensuring a base level of consistency across states would promote administrative efficiency for issuers working on multiple submissions. Further aligning FFE and SBE requirements would also minimize inconsistencies in the way data is submitted for certification and displayed to consumers.

With respect to certification timelines, submission requirements, and interpretation of data elements, we recommend general guidance to states to promote a streamlined submission process for issuers offering QHPs across multiple FFE and SBE states. Specifically, the 2014 templates and instructions left room for state Departments of Insurance (DOIs) to interpret the meaning or intent of certain requirements. This resulted in inconsistent interpretations across states for certain data elements. For example, in two different states, the same plan offered with and without vision benefits may have required separate plan IDs in one state and been allowed to share a plan ID in another state. Such variation can have substantial impacts on issuer resources

allocated to template submission. We request that CMS provide additional guidance to clarify which requirements and data elements are open for interpretation by state DOIs.

It is also important that CMS work with FFE and SBE states to clarify the full end-to-end certification process, including submission deadlines and any steps that require approval by the state DOI. This will also be extremely important as states may transition from FFE to SBE later in 2014. During the 2014 plan year resubmission windows, issuers were under tight timelines to submit data corrections, which often required the state's approval. For example, during Plan Preview, template changes required state approval before an issuer's petition could be submitted to CMS but many states were not aware of this requirement, which led to delays in submitting petitions.

Attached you will find an appendix containing detailed comments on the various data templates. We look forward to working with you over the coming months to achieve successful Exchange implementation. Please do not hesitate to contact me if you have any questions at 202-861-1491 or jthornton@ahip.org.

Sincerely,

Jeanette Thornton
Vice President, Health IT Strategies

AHIP Detailed Comments on the 2015 QHP Application

QHP Application Submission

Process Recommendations:

- HIOS should only lock down submitted files after the close of the submission window. We recommend that HIOS allow issuers to delete an uploaded file so that issuers can remove an incorrectly uploaded file up to the point of final submission. Issuers should not be required to submit a justification for reviewing a file prior to the close of the submission window.

- We recommend instructions clarify whether issuers are expected to provide a single template for individual and small group markets or whether it is possible to differentiate between markets within the issuer level. For example, one issuer encountered a situation of the small group template overriding the individual market template, resulting in incorrect rates in production. Specifically, we recommend each template include a field for the issuer to indicate whether the template is for individual, small group, or both, at the issuer level. This would allow issuers to submit templates separately for each market, or jointly if desired, so that all exceptions at the product level do not need to be entered separately.

- Related to template consistency between markets, we also recommend CMS provide issuers with a map of how templates are uploaded into Plan Compare. This will allow issuers to identify limits between products for completing templates. For example, there were clearly defined separate submissions for medical and dental products. However, this distinction was not so clearly drawn for the submission of small group and individual QHPs within medical and dental lines of business.

Template Functionality:

- Issuers need advance notice of which Excel version (e.g., 2010) will be used for the 2015 QHP application. If an issuer does not use or have access to the version of Excel that templates are published in, macros may not work, which would impact an issuer's ability to accurately complete and submit. We recommend that issuers have flexibility to use whatever version of Excel is preferred by their companies.

- Likewise, template upload should be compatible with all major browsers (e.g., Internet Explorer, Chrome, Firefox). If this is not possible, template instructions should indicate browser limitations so that issuers can begin the process for corporate approval to install an alternate browser if necessary.

- Templates should improve copy and paste functionality to significantly reduce man-hours in creating or duplicating plan information. For example, if the Rate Template was too large, the issuer had to split it into two templates, a process that required over 30 minutes to copy and paste the plan ID, populate all ages for that plan ID, and repeat for all plan IDs (of which there can be over 100). This process would only take moments if the cells could be copy and pasted instead.

- We recommend better integration of the Rating Template, Service Area Template, and Plans and Benefit Template for simplified data entry. The 2014 templates had complex workflows and many reference documents, making testing and troubleshooting difficult.

- Key plan fields should never be read-only (i.e., validating a template should never lock any fields).

- During the 2014 submission, often templates would successfully validate but would then fail to upload to HIOS/SERFF. To streamline this process, we recommend HIOS and SERFF checks be included in template validation checks. If templates fail HIOS/SERFF checks, issuers can then make those corrections prior to attempting to upload.

Template-Specific Recommendations

Administrative Template:

- We recommend streamlining the collection of issuer administrative data. Specifically, CMS should consider the value of the volume of fields that are collected versus how, and if, they are used. For example, a significant number of plan contacts were collected but not necessarily used as indicated, which then required additional manual work by issuers to provide CMS with contact information.

- Specifically, we recommend that CMS review areas of overlap with Plan Finder to eliminate duplicative submission requirements. Administrative data could be collected through a common submission, with separate On-Exchange and Off-Exchange fields for data elements like customer service phone numbers and URLs.

- The data dictionary should include definitions for all requested points of contact so that issuers can assign the appropriate parties. Template instructions should clearly indicate the purpose for each requested issuer point of contact and customer service phone number so that issuers can provide the correct contact information. It is also important that CMS use contact information as indicated in the instructions to ensure that consumers are directed to the

appropriate customer service resources and that CMS works with the appropriate issuer contacts.

- The Administrative Template and plan filings required different information for plan marketing name, which led to inappropriate use of names (e.g., legal name versus plan marketing name). Template instructions should explicitly state whether HIOS or the Administrative Template will be used as the source for plan marketing name to ensure the correct name is displayed to consumers.

- We recommend that the Customer Service field allow issuers to specify additional phone numbers to more accurately direct consumer calls (e.g., billing versus benefits information).

- Instructions should provide additional guidance on requirements for the Organizational Chart. Specifically, we request clarification on whether individual names are necessary or if position names and responsibilities are sufficient as well as whether this information needs to be provided at the plan or company level.

Essential Community Providers Template:

- Instructions should provide further clarification around the Essential Community Providers (ECP) template, especially as it relates to combining QHP and SADP provider information. Any information on the ECP safe-harbor standard for the 2015 plan year should be provided to issuers as soon as possible to they can adjust their networks appropriately.

- Completing this template required issuers to refer to a number of sources for ECP data. We strongly recommend that CMS compile all provider information (i.e., ECP, 340B, and Indian Health Service) in one database to serve as a comprehensive source of ECPs for issuers to build networks. We also recommend that NPIs and TINs are included in this list to support a more accurate and automated compliance process.

- CMS should ensure that provider information is up to date to reflect active providers, current contact information, etc. Not all provider information in the non-comprehensive ECP and American Indian / Alaskan Native provider lists was current. When issuers reached out to provider entities, they often discovered that addresses or other contact information were incorrect. Provider lists should be updated at regular intervals (e.g., every three months).

- We recommend that provider type is removed from the template. Issuers do not store this data and must look up providers individually on the HHS website. This seems to be unnecessary manual work when HHS should be able to crosswalk this information from its ECP list.

- We request clarification on how to address contracting with individual providers (i.e., physicians, nurses) within a group as opposed to the entire group. This issue arises because of issuers' internal contracting policies. Issuers were not always able to match on the entity level, but did contract with individual physicians. The templates should allow issuers to indicate whether they contracted with an individual provider within a professional group or the group as a whole.

- The template should allow an issuer to include an organization with multiple locations but the same NPI. In the 2014 template, NPI was an optional field yet entering duplicate NPIs caused the template to fail validation.

Accreditation Templates (NCQA or URAC):

- The timeline and method for recording accreditation status for 2014 was not consistent with existing accreditation processes. For example, there were instances of CMS deadlines conflicting with the deadlines/timelines set by accrediting bodies. We recommend that CMS obtain accreditation information directly from the accrediting body with the issuer subsequently confirming and approving that information.

Network Template:

- Template instructions should clarify the impact of making a change in the dental templates on the medical templates. Specifically, when using the same legal entity, issuers should be able to combine a SADP network with a medical network on the same template to ensure that all Plans and Benefits Templates link to the correct network.

Provider File:

The Supporting Statement indicates that CMS intends to collect a Provider File with information detailing the QHP issuer's provider network, including provider name, county, and type. We understand CMS' interest in maintaining a searchable provider directory on the FFE to allow consumers to use provider information in plan selection process. However, maintaining accurate and up-to-date provider information is a complex process that can be extremely challenging due to the fluid nature of provider directories. It also quite difficult to match providers in various individual issuer provider directories across multiple health plans without having a way for providers to update this information themselves and then update the directory. We understand that some SBEs, including Washington and Colorado, collected provider directories from plans and asked issuers to submit updates on a monthly basis. Collection of provider directories in these states has been problematic, and issuers note that a monthly resubmission is not frequent enough as provider contracting and contact information can change on a daily basis.

Because a searchable provider directory is not a necessary feature to support plan selection, we recommend that this requirement is delayed for the 2015 QHP application. This will allow CMS and issuers to focus on functionality around basic certification requirements to ensure that data is submitted and displayed accurately and consistently. Delaying this requirement to a future QHP certification application will also allow CMS and issuers to develop an efficient approach to compiling provider directory information to support consumer decision-making across multiple issuers. CMS should also consider leveraging existing provider databases to support this functionality in the future.

Plans and Benefits Template – General:

- All required data should be clearly marked as required in the template and the template instructions.

- Overall, the template had many password protected fields. We recommend allowing issuers more flexibility to delete/add fields, highlight, etc., to improve the process of completing templates and ensuring benefits are accurately reflected.

- The template should allow issuers to make changes to the Benefits Package tab (i.e., add a benefit or change Covered / Not Covered designation) without losing information in the Cost Sharing Variance (CSV) tab. For example, when working with state DOIs, issuers needed to make many changes to benefits, which then required information to be reentered in the CSV tab. Specifically, we recommend that the template include a "Delete Benefit" button similar to the "Add Benefit" button such that when an issuer removes a benefit from the Benefits Package tab, that update is reflected when the CSV tab is refreshed.

- Error messages should provide a precise indication of the type and location of an error that is preventing the template from being finalized and validated. Specifically, when the desktop validation process results in a run-time error, it should include the details of which cell is misformatted and the correct format requirements. Issuers can then correct formatting errors without engaging the Help Desk to locate and correct the error.

- Formatting of the Benefits Package and CSV tabs made it difficult to review data or conduct quality assurance checks. We recommend a "QA Check" button on the Add-In file to extract data into an Excel document that facilitates plan-by-plan review by consolidating information found on the Benefit Package and CSV tabs in a more vertical, easy-to-read format. Some state exchanges, such as California, used this method before finalizing plan details on the Exchange website.

- The 2014 AV Calculator used issuer cost sharing for coinsurance but member cost sharing for copay amounts. However, the Plans and Benefits Template used member cost sharing for both coinsurance and copays. This inconsistency created confusion technical problems. For example, during testing, Healthcare.gov displayed issuer cost sharing for coinsurance instead of member cost sharing. We recommend using member cost sharing, which is the industry marketing norm, for both coinsurance and copays in both the AV Calculator and the Plans and Benefits Template.

Plans and Benefits Template – Benefits Package Tab:

Functionality

- The Benefits Package tab is restricted to 50 plans per package. We recommend increasing this limit so that issuers do not have to create multiple benefit packages for the same type of plan design.

General Information

- Essential Health Benefits (EHB) and State Mandated Benefits were not always accurately listed in the template, with inconsistencies between templates and Benchmark Plan policy documents. EHB and State Mandated Benefits should be confirmed with the state DOI before finalizing the state add-in file or templates should allow issuers to make edits to list these benefits correctly.

- We also recommend that EHB are populated in the template consistently for Individual and SHOP plans to facilitate conducting cross-functional reviews to ensure that the templates were interpreted and completed consistently for all products.

- Template instructions should provide more detailed guidance for the use of the EHB Variance Reason field, including examples, to clarify when each variance reason should be applied.

- Template should include a field for issuers to indicate when a carrier (usually an HMO) uses or must use another issuer to underwrite out-of-network coverage. State laws require disclosure of the legal name of the underwriting company(ies) on all filed documents and marketing materials. Some states instructed issuers to add this to the comments section, although with this approach information is not clearly presented to consumers on Plan Compare. This information is also not included on the Summary of Benefit and Coverage (SBC) due to lack of space.

Plan Information

- The Product Type drop-down menu should include options for EPO/PPO and PPO/EPO to better align with state filings for products that are classified as both EPO and PPO and ensure plan type is accurately represented to consumers.

- Service Area is only identified by Service Area ID in the Plans and Benefits Template; however, this could lead to the same ID being used to represent different plans in the same state. For example, an issuer may have in one state with the same Service Area ID but different service area or service area name. Similarly, in one state an issuer may have a Service Area ID for a medical product that only applies to part of the state but the same Service Area ID for a Standalone Dental Product that is sold statewide under the same corporate entity. We request clarification on whether duplicative IDs could result in products being offered in parts of a state where they should not be sold or precluded from being offered in parts of the state where they should be available. If so, we recommend additional Service Area identifiers (e.g., name) be added to this Template.

- We recommend that "Notice Required for Pregnancy" is removed from the template. This granular piece of information should not be collected as part of a basic overview of benefits and would be better addressed in specific plan documents. Issuers already define the requirements for such notice in its plan certificates as an ERISA/DOL requirement. If this data element is not removed from the template, we request additional clarification for why this information is required.

- We recommend that the field for "Plan Level Exclusions" be revised to allow issuers to more easily indicate no out-of-network coverage except for emergency services. In the 2014 templates, this field was used to indicate that out-of-network services are not covered (i.e., most HMO products). For most other products, issuers had to list out-of-network services as plan-level exclusions, then indicate "Not Applicable" on the CSV tab and list $0 copay and 0% coinsurance for out-of-network services for every benefit listed, except emergency services. This resulted in a large amount of manual entry and the potential for data entry errors. We specifically recommend adding a field in the Benefits Package tab to indicate "Out-of-Network Coverage (Except Emergency Services)" such that selecting "No" would block out all of the "Out-of-Network" fields in the CSV tab, except for emergency services.

- Instructions should provide additional clarification of the drop-down menu options to indicate child-only plan offerings. Guidance was provided by HHS later during the submission process to distinguish the responses and should be included in template instructions.

- We recommend that the drop-down menu for "Disease Management Programs Offered" include "Weight Loss Programs." Because "Weight Loss Programs" is not currently included, it does not appear to be a covered benefit on Plan Compare.

Benefit Information

- We recommend reevaluating which benefits are displayed on Healthcare.gov to support consumer decision-making. Some benefits currently displayed such as hearing aids, bariatric surgery, or acupuncture may not be priority benefits for most consumers to determine whether coverage will meet their needs.

- Template instructions should include a more detailed description for each benefit, including examples, to mitigate errors in interpretation and ensure benefits are accurately and consistently reported. For example, some states associate the Rehabilitation benefit with OT/PT/ST while others associate it with Substance Abuse Rehabilitation. As another example, "Weight Loss Programs" should be clearly distinguished from "Nutritional Counseling" and "Bariatric Surgery."

- Benefit descriptions should also clarify how information should be entered for benefits that are covered based on place of service, especially those that are diagnosis-related rather than service-related, so that benefits are displayed consistently across all plans (e.g., most common scenario, worst case scenario).

- Template instructions should provide specific examples of what information should or should not be included in the "Exclusions" and "Benefit Explanation" fields and how that information will be used or displayed. In the 2014 templates, these fields were used as catch-all categories to convey exclusions, limitations, coverage options, or any other disclaimer an issuer wanted to include. However, it was not clear how the field would display to consumers, which led to concerns that its display or interpretation could lead to confusion for consumers. In addition, issuers included language directly from plan documents to communicate standard benefit "Exclusions" and "Explanations" that would be important to a consumer (e.g. "must be medically necessary", "must be a participating provider"). Such explanations did not actually limit the benefit, but if these fields were populated the issuer had to complete the "EHB Variance Reason" field, but it was not clear which option to select.

- We recommend the following specific changes for benefits listed in this template:
    - "Prenatal and Postnatal Care" should be listed as separate benefits.
    - "Mental / Behavioral Health and Substance Abuse Disorder" should be listed as separate benefits. Mental / Behavioral Health services and Substance Abuse Disorder

services are not required to have identical cost shares. For example, plans may cover services for one under specialist provider cost sharing but the other as primary care provider cost sharing. Combining the two benefits may lead to inaccurate cost sharing being displayed to consumers.

- We recommend that all prescription drug information is removed from the Plans and Benefits Template and listed only in the Prescription Drug Template. The current approach is disjointed, with some drug benefit and cost sharing information being included in each template. Issuers would prefer a more streamlined approach that lists all drug information in one place. This would eliminate duplicative entry of drug information and potential errors or inconsistencies.

Deductible and Out-of-Pocket Expenses

- We recommend the template provide additional flexibility for issuers to indicate when benefit information is not applicable to more accurately represent plan information. For example, Indemnity plans do not have In- or Out-of-Network benefits and HMOs only have In-Network benefits, but the template requires a value to be entered in each field for the template to validate. We recommend that "Not Applicable" be added to the drop-down menus for Deductible and Out-of-Pocket Exceptions fields.

Plans and Benefits Template – Cost Share Variance Tab:

Plan Information

- Template should allow issuers to create a separate marketing name for each CSR plan variation. The 2014 templates did not allow issuers to assign unique marketing names to each silver plan variation, including American Indian / Alaskan Native plans, which typically do not share the same marketing name as the standard plan.

Actuarial Value

- The Issuer Actuarial Value (AV) field requires entries formatted as a percentage; if entered as a decimal, the template validation passes but triggers errors upon upload. This resulted in entering what issuers may consider incorrect values for In- and Out-of-Network respectively. We recommend that this field allow for decimal entries.

- We recommend the embedded and standalone AV calculators be reviewed and revised to ensure they result in the same calculations. In the templates used for 2014 submission, the embedded calculator did not always result in the same value as the standalone version; the two calculated values were frequently very close but not exactly the same.

- For the 2014 submission, CMS recommended a number of workarounds to get templates to validate due to glitches in the AV calculator. For example, CMS recommended entering "member deductible" and "drug deductible" as ".0001," causing coinsurance to display as ".01%." This allowed issuers to generate an accurate AV, but was inaccurate because the coinsurance was truly 0%. Such workarounds for the purpose of template submission also resulted in incorrect data being displayed during Plan Preview, which then required subsequent fixes.

- AV is rounded to four decimal points in the Plans and Benefits Template but rounded to 3 decimal points in the Unified Rate Review Template, which can result in filing different AV for the same plan between the two templates. We recommend formatting restrictions for this field apply consistently across both templates.

URLs

- The template should allow issuers to tie SBC URLs to all plans, including silver plan variations, not just base plans.

Cost Sharing Attributes

- In general, there are a number of adjustments that can be made to the CSV tab that would allow issuers to submit information in a way that more accurately reflects cost sharing for specific plan designs and covered benefits. Downstream this would also result in cost sharing information being more clearly and accurately displayed to consumers on Plan Compare.

- To more accurately reflect various cost sharing designs and to ensure consumers have a clear understanding of out-of-pocket costs, we recommend that the dropdown menus for cost sharing fields include options for "Not Applicable" or "Not Covered."
    - Not Covered will allow issuers to indicate that a benefit is not covered instead of populating "100% Coinsurance" and "No Charge" for copay.
    - Not Applicable will allow issuers to list copay as N/A if it is a coinsurance benefit and vice versa, rather than "$0 Copay" for a coinsurance benefit or "0% Coinsurance" for a copay benefit.

- We recommend the template include functionality for an issuer to assign "plan level" coinsurance that auto-populates coinsurance fields with the coinsurance value. Providing the option for a standard plan level coinsurance (one for in-network and one for out-of-network) that populates across all benefits would streamline the submission process and mitigate the potential for errors when issuers need to change values in the template.

- We recommend tying drop-down menus in the CSV tab to details entered in the Benefit Package tab. For example, if a benefit is identified as "Subject to Deductible," the drop-down menu for that benefit on the Cost Variance Sheet should be "$X after Deductible" or "X% After Deductible." This would minimize discrepancies between the Benefit Package and the Cost Variance Sheet, help in reaching the correct AV, and ensure benefits are accurately displayed to consumers. For example, "$X Copay per Day after Deductible," is especially important for the Hospital Inpatient benefit.

- We recommend the ability to display more nuanced cost sharing structures, including:
    - Maximum dollar amount (e.g., 50% coinsurance up to a maximum of $500)
    - Combination cost sharing, including as well as combination cost sharing options, such as copay/coinsurance/no charge/not covered up to a certain dollar amount, then the option of copay/coinsurance/no charge/not covered.

- We recommend the template allow issuers to indicate whether a deductible is per individual or per family. Templates do not currently allow issuers to enter information for an Individual Deductible. For a QHP that does not establish a Family Deductible, consumers are directed to the Plan Brochure for deductible information rather than listing the Individual Deductible in Plan Compare. This could result in consumers having incomplete or confusing information about out-of-pocket costs.

- It would be helpful to include an indicator for issuers to specify how individual and family out-of-pocket costs and deductibles accumulate. For example, there was confusion in the 2014 templates and the display of data in Plan Preview and Plan Compare under individual deductibles whether one individual could meet the total deductible for all members of the family or if each individual must meet the deductible amount for coverage of benefits to begin.

- We recommend the ability to distinguish between inpatient and outpatient deductibles. The Template currently does not accommodate plan designs with cost-sharing that features separate inpatient and outpatient deductibles. Issuers cannot enter multiple deductibles and cannot indicate whether a service is covered after the inpatient or outpatient deductible. In some plan structures, both the inpatient and outpatient deductibles contribute to the out-of-pocket maximum.

- "Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)" field must be accurately displayed to consumers in Plan Compare. That is, the "Prescription Drug Out-Of-Pocket Maximum" field in Plan Compare should display "Included in Combined Medical and Drug Maximum Out-of-Pocket." QHPs that were submitted with combined "Maximum

Out-of-Pocket for Medical and Drug EHB Benefits (Total)" were displayed in Plan Compare as if they had a separate prescription drug out-of-pocket maximum.

- If an issuer selects Multiple In-Network Tiers, In-Network cost-sharing for Tier 1 and Tier 2 must be entered for every benefit. However, an issuer may only tier a subset of benefits (e.g., office visits) but for all other benefits would have to enter identical cost sharing for Tier 1 and Tier 2 for all other benefits. We recommend that the template include an indicator for which benefits are in more than one tier to streamline the submission process and more clearly communicate benefits to consumers.

- The template should also reflect multiple cost shares for tiered benefits. The template supports a plan that has two network tiers, but does not support the ability to indicate how benefits are tiered under a single network plan design. As noted previously, cost sharing may vary based on place of service with an issuer charging higher cost sharing for outpatient services rendered in a hospital setting versus a physician's office, fee standing clinic, or ambulatory surgical center. As another example, a plan may have one network, but charge lower cost-sharing when members utilize high-value providers who are ranked higher for quality and affordability. The template currently does not allow issuers to indicate such cost sharing approaches.

Prescription Drug Template:

- As noted above, we recommend that all prescription drug benefit and cost sharing information be listed in the Prescription Drug Template. Including all drug information in one template will simplify submissions for issuers. In addition, during form filing it will allow issuers to point state DOIs to one source for prescription drug information to demonstrate how drug benefits would be administered.

- To support prescription drug information on one template, we recommend including similar benefit and cost sharing information by generic, brand, specialty drugs, etc. (i.e., copay and coinsurance amounts in- and out-of network for each tier). In addition, we recommend the adding "not applicable" to cost sharing drop-down menus.

- Overall, issuers would appreciate increased transparency into the need for certain data fields for consumer information versus certification purposes. Not all data submitted in this template for the 2014 submission was consumer-facing. For example, issuers must submit a drug list but were not provided with a way to update that list, which changes throughout the year.

- The template should accommodate five- and six-tier prescription drug benefits. The 2014 Plans and Benefit and Prescription Drug Templates were not consistent with respect to the

number and type of tiers that issuers could select. Prescription drug information reflected in these templates should not be limited to generic, preferred-brand, non-preferred-brand, and specialty. We recommend allowing preferred generic, non-preferred specialty tiers.

- In addition to these tiers types, we recommend the template include an additional field for issuers to manually enter a description or title for each drug tier to provide additional clarity if their tier types vary from those allowed by the template.

- We support the inclusion of an additional field to indicate whether a drug is a "Medical Drug Covered Under Medical Benefit" or "Preventive Drug Covered at $0 Cost" in the draft Prescription Drug template in the PRA. It is critical that this field be included in the final template for the submission of information on prescription drug benefits.

- In addition, we recommend that above field include an option for issuers to indicate whether a drug is in a class or tier of drugs that is excluded from coverage (i.e., "Drug Excluded from Covered Benefits"). Currently the only way to reflect this information in the template is to enter 100% Copay in the cost sharing field for a tier of drugs but issuers would prefer to explicitly designate a drug as not covered.

- We recommend that the pharmacy benefit page be allowed to reflect coinsurance plan designs with the template.

- The template restricts cost sharing values to whole numbers and thus exact copay values cannot be listed to the cent. This resulted in States identifying discrepancies in cost share amounts in the Prescription Drug template compared with contract filings. To ensure that copay values are reflected accurately, we recommend that the template allow dollars and cents values.

- The templates do not allow issuers to indicate benefit structures that include cost share ranges for prescription drugs. We recommend the addition of fields for minimum and maximum drug cost sharing.

- We recommend changes to accommodate different supply amounts for the retail and mail-order categories, which are currently limited to 3-month supply quantities. For example, an issuer may have specialty tiers that are available via mail order, but are only provided in a 30-day supply.

- With regard to drug lists, we recommend a comprehensive list of drugs that fall under each USP drug class by distinct chemical entities. In addition for each state benchmark drug list, we recommend listing the specific drug that is covered as well as the drug count.

- We recommend that CMS review the RxCUI list for gaps.

- We recommend amending the output of valid RxCUI count. Today's output reflects drug class, drug category and RxCUI count. Along with this information, the specific RxCUI number should be added for easier reference.

- We ask that CMS provide issuers with the RxCUI to USP 5.0 category/class crosswalk used to assign RxCUIs to category/class counts. Because the count is limited to one chemical entity, it is not clear in which USP category/class drugs with multiple salts and forms are counted. To minimize uncertainty, we recommend the template allow issuers to indicate to which USP category/class a submitted drug is intended to be attributed.

Service Area Template:

- As previously noted under general submission recommendations, the template guidelines/instructions should provide information on the interactions between templates. Specifically, we recommend that the Service Area Template instructions clarify how fields in that template impact other templates.

- To reduce the burden of entering county names, especially for large networks, we recommend that the field is formatted so that a user can type in the county name and the template automatically brings up the matching county. Currently, this field is a drop-down menu that can be cumbersome to use.

Rate Template:

- The final Market Rule regulation states that younger enrollees could be charged a lower tobacco use factor than older enrollees provided the tobacco use factor does not exceed 1.5:1 for any age group. As a result, when age and smoking factors are applied, a 65-year-old smoker may have a rate that is more than three times higher than a 21-year-old smoker. However, because of "system limitations," template validations for the 2014 submission could not process a premium rate for a 65-year-old smoker that is more than three times higher than the premium of a 21-year-old smoker. The validations in this template should be updated to allow the full premiums permitted in regulation to be submitted.

- We recommend that non-validation macros are removed, including those that hide, unhide, and populate data on the template. These macros make it more difficult for issuers to automatically populate the template with data from plan rate systems.

Business Rules Template:

- The Business Rules Template needs to be revised so that all questions are consistent with statutory and regulatory requirements. We understand that the 2014 template was finalized prior to the Market Rules, which resulted in some questions that were inconsistent with or made unnecessary by that final rule. For example, the answers to questions related to smoking, maximum dependent age, and age for rating and eligibility purposes are all prescribed in regulations yet these questions were included in the template. Any business question that is already determined by statutory or regulatory requirements should be removed.

- Template instructions should provide additional clarification around the requested business rules, especially those related to dependent type definitions. 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 as such in Plan Preview.

- We recommend the template incorporate a different format for issuers to submit allowed relationship relationships. The pop-up menu was extremely cumbersome to use and did not allow issuers to automate its completion. As an alternative, we recommend that the pop-up menu is removed and allowed dependent relationships are captured in Excel cells similar to other information in the template.

- Dependent relationships listed as potentially allowed relationships to the subscriber need to be clarified. Template instructions should provide more explicit definitions and examples for each dependent relationship.
    - Specifically, lack of indicator for a court-appointed dependent and the use of "Ward" to signify "over-aged disabled dependents" needs to be explicitly defined in the instructions. As many issuers may use the designation of "Ward" according to its true legal meaning, we recommend an alternative designation to indicate disabled dependents so that issuers to not need to investigate each enrollee with a relationship code of "Ward."
    - Allowed dependent relationships in this template should be described from the perspective of the adult subscriber such, that if children and stepchildren are allowed as dependents of an adult subscriber, then siblings and step-siblings are allowed as dependents on a child-only policy. If this is not possible, there should be a separate field to designate allowed dependent relationships for child-only plans.

- We also recommend that relationship codes provide additional flexibility for issuers to reflect state-specific requirements related to dependents. For example, Florida requires issuers to

provide coverage for a newborn of a covered dependent for 18 months. Existing relationship codes do not allow issuers to accurately reflect this state-specific requirement.

- We recommend that business rules for Plan Finder are aligned with those for QHPs offered on the Exchange so that plans are displayed to consumers in a consistent manner.

Attestation and Justification Templates:

- Functionality should be improved to make these templates more user-friendly. Issuers should be able to enter and save information directly into the form, not have to print and scan the completed form into a PDF for upload into HIOS as was the case for many issuers with the 2014 template. We recommend that the forms be provided in Word format so that issuers can complete the templates without the PDF field size limitations.

Submission of Dental Plans:

Submission Timeline

- We recommend that submission of Standalone Dental Plans (SADPs) take place at the same time as submission of QHPs. Submission of dental applications took more time than expected and an earlier submission window will provide needed time to complete and submit templates.

Dental Templates

- Overall, because the dental templates were modified versions of the QHP templates, they were not suited to coverage of dental benefits making it difficult for issuers to accurately complete the templates. We recommend that CMS create unique dental templates so that submission requirements are specifically tailored to the design of dental benefits for key templates, including:

    - Plans and Benefits Template – Template was not suited for dental benefits, but was more aligned with medical plan requirements. For example, in some cases the dental template referred to the deductible as the "medical deductible" and the only services pre-filled for dental plans were the exam, basic, major, and accidental services for adult in child, requiring issuers to enter custom detailed services.

      We recommend revising the dental benefit categories to clarify which benefits should be assigned to which categories (i.e., preventive diagnostic, major, and minor).

Issuers should also have the flexibility to add benefits to the template (e.g., Minor Dental Service) to display on Plan Compare.

- Rate Template – Pediatric ages are different for dental. Template should allow issuers to enter rates for ages 0 to 18 years only. The template currently requires entering rates for each age above 20; we recommend this requirement is eliminated for dental rates.

- Business Rules Template - Dental business rules template needs to accommodate rating more than three dependents; currently the template only has a category for "3 and above."

- Templates should include fields to provide plan details (e.g., waiting periods) for display in Plan Compare.

- For 2014 submissions, issuers were able to indicate whether dental rates were estimated or guaranteed. However, CMS has not provided guidance on how estimated dental rates will be processed. If rates are again allowed to be submitted as "estimated," we recommend coordinating the process with the CMS enrollment team to develop this approach prior to 2015 open enrollment.

Communication with Issuers

Q&A Sessions and FAQs:

- Delivery of submission information and guidance by CMS needs to be streamlined, clear, consistent, accessible to all stakeholders, and timely.

- Plan Management Q&A sessions (RegTap calls) should continue throughout the 2015 submission process. This should include focused, template-specific sessions prior to the submission window to walk through templates and instructions, focusing on revised fields, requirements, or functionality. We also request daily Q&A open forums during the submission window to troubleshoot submission questions. Similar sessions were very helpful in the final weeks of the 2014 submission window.

- We recommend adjustments to the Q&A sessions to make them more productive to issuers and CMS. Specifically, the process for submitting and responding to questions on Q&A calls can be vastly improved.

    - First, we recommend an interactive chat window to allow issuers to communicate and troubleshoot with CMS and other issuers in real time. This capability is available during

testing calls and provided value to issuers while also reducing the burden on CMS. This interactive chat allows issuers to see if others are submitting similar questions, which reduces duplicative submissions and highlights patterns across issuers. It also allows issuers to use each other as a resource and share knowledge or fixes in real-time.

- Second, the process for CMS to respond to questions verbally or via chat should be revised. During the 2014 submission process, CMS released FAQs subsequent to Q&A calls, but there was often a significant lag time and FAQ documents were often limited to select questions that CMS opted to answer. We recommend that CMS publish FAQs within 1-2 business days following Q&A sessions. These FAQs should be in the format of an issue log, listing all unique questions submitted during a call, a response to the question, or a projected time to respond. Listing unanswered questions and projected time to response should mitigate duplicative questions and inform issuers that CMS is working to resolve.

- We recommend that Q&A sessions do not limit the number of participants from each organization. Often issuers need multiple experts from their organizations to hear the information provided at these sessions. Specifically for QHP template review and submission, it would also be helpful to have these sessions limited to specific topic areas and/or templates to ensure that the right CMS subject matter experts and issuer experts can participate on the appropriate calls.

- We recommend that a comprehensive CMS team participate in Q&A calls to minimize the number of questions that cannot be resolved in real time. For Q&A sessions that are focused on a certain area it is understandable that off-topic questions cannot be answered in real-time. However, too often CMS does not have a comprehensive group of policy, operations, and technical staff on hand to respond to those questions that are within the purview of the session's topic.

- Overall, FAQs need to be published in a more easy-to-digest and searchable format. Specifically, published FAQs should note the date of initial response and date of update, if applicable. In several instances, CMS guidance was revised after the initial FAQ publication and it was difficult to identify when responses were revised. We recommend the FAQ repository include a field for date of update, if applicable, and that the default search setting lists FAQs by the most recently published or updated entries.

- CMS recently made updates to the way FAQs are stored on the RegTap website. This format, which includes all Q&As in one central, searchable location is preferable to issuing individual FAQ documents, which made it difficult to find specific topics or Q&As. However, this new FAQ repository is extremely difficult to use and the search function does not successfully return Q&As when keywords are entered as search terms. In addition, some

FAQs that were published in the original PDF documents were not transferred to this new FAQ repository. This FAQ repository needs to be a comprehensive Q&A source and its search functionality needs to be improved in order to be a useful resource for issuers.

Help Desk Responsiveness and Ticket Resolution:

- Help Desk procedures and ticket resolution processes must be reviewed and revised prior to the next submission window. There is much room for improvement over the approach taken for 2014 submission, which was prone to errors (e.g., assigning tickets for a question submitted by another issuer, losing tickets) and had extended turnaround times, often 1-2 weeks or more, which significantly impacted issuers' abilities to meet deadlines.

- We recommend that Help Desk tickets are resolved (not just responded to or escalated) within a reasonable timeframe such as 2-3 business days maximum. Questions that are not addressed in a timely manner will impact issuers' ability to meet the submission deadline.

- We strongly recommend that issuers are assigned a dedicated point of contact with a comprehensive understanding of the templates and submission process to quickly address issues in a timely manner. In the final week of the 2014 QHP submission window, issuers were assigned a specific individual as a single point of contact, which was a more successful system for resolving issues. We recommend that issuer Account Managers are leveraged for this role. This will provide ownership and a more streamlined process for resolving tickets.

- We recommend establishing protocols for Account Managers to review and approve certain requests for changes that do not have a substantive impact on plan offerings (e.g., URLs, explanations), in order to expedite the process of resolving lower-priority tickets.

- Often when issuers called the Help Desk to check the status of a ticket, staff did not know whether a ticket was already being addressed. An online system that issuers could log in to and view the status of ticket resolution would help mitigate the creation of duplicate tickets and facilitate collaboration between CMS and issuers to resolve tickets.

- When CMS responds to a question via email, we recommend that the response always include the original question and any other communication on the topic (i.e., the full email thread) with the response. There were numerous instances in which CMS responded to a ticket without reference to the question, which caused confusion when issuers had submitted multiple questions and weren't sure which one CMS response was addressing.

- We recommend a clearly defined prioritization of issues with a clear hierarchy of which issues need to be resolved immediately so that tickets are appropriately triaged and not all

issues are escalated to Tier 2. This priority list of issues should be used by the Help Desk and shared with issuers, and updated as needed to reflect emerging priority issues.