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Submitted via email to OIRA_submission@omb.eop.gov

Mr. Joshua Brammer
CMS Desk Officer
Office of Information and Regulatory Affairs
Office of Management and Budget
New Executive Office Building
725 17th Street NW
Washington, D.C. 20503

Subject: QHP Certification and Other Financial Management and Exchange Operations Information Collection Request (CMS-10433) – AHIP Comments

Dear Mr. Brammer:

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 Collection Requests related to Qualified Health Plan (QHP) Certification and Other Financial Management and Exchange Operations published November 21, 2012 in the Federal Register (77 Fed Reg. 69846) and the subsequent detailed information posted on the CMS Paperwork Reduction Act (PRA) website. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate the time CMS staff has taken to gather health plan input on the various forms and templates that will be used to support QHP certification for the Federally-facilitated Exchange (FFE) and for State-partnership Exchanges (SPEs). We are pleased to see consistency across FFE states in the proposed data templates; however, we are concerned about the wide variation that may occur in the data submission processes for State-based Exchanges (SBEs). While the supporting statement notes that SBEs will find these templates useful to streamline data submissions and Federal officials are "strongly recommending" that states use the same templates to reduce burden on health plan issuers, a strong statement from HHS is crucial regarding the importance of reducing health plan burden associated with the information submissions and to provide consistent information on QHPs to consumers.

Given the quickly approaching state and exchange filing deadlines, we ask that HHS work with states to ensure a uniform data collection process and standard data templates to the greatest extent possible. We also note the importance of providing consistent information on QHPs to consumers. The use of a standard data template across states will be critical to providing

consumers with easy to understand, consistent information about QHPs to reduce confusion and support consumer decision making.

The comments submitted in this letter represent AHIP's initial comments on this information collection request. Given the limited duration of the comment period, the interactive effect of all of the proposed regulations, and the complexity of the federal/state allocation of responsibilities, we have endeavored to provide a timely reaction to this proposed regulation. We continue to analyze the data templates and their relationship to the *Essential Health Benefits / Actuarial Value* proposed regulation, the *Notice of Benefit and Payment Parameters* proposed regulation, and the *Market Rules* proposed regulation, as well as the collective impact of these rules and associated information collection requests. As the Department proceeds to finalize these foundational rules, which will impact the data collection templates and processes, and moves forward with implementation, we will continue to provide feedback from health plan operations leaders who are preparing for 2014 by designing benefits, developing products, and pricing offerings.

AHIP reiterates our previous comments that the data collected from health plans to support the QHP certification process must be consistent with existing state requirements and should not duplicate any data collection or regulatory reviews already conducted by applicable state agencies. We understand that CMS proposes that QHP issuers submit their QHPs for review and certification by the exchange before having the necessary state approval of rate and form filings. As we described in our comments dated July 5, 2012, on the first draft of the QHP application, ideally, only QHPs with necessary state form and rate approval should be submitted to the exchange for review. Given the time considerations for year one, we understand that this is not an option for the 2014 plan year; however, we urge CMS to revert back to requiring state review and approval prior to submitting the QHP to the Exchange in future years. The data collection from QHP issuers should be built upon a QHP certification process in which issuers first submit necessary information for approval to the State, and then submit any required supplemental data to the Exchange.

We are concerned that some of the information proposed to be collected by HHS to support QHP certification appears to have the FFE conduct a re-review of information collected and reviewed by the state. This has the potential to undermine the role of the existing state regulatory review, create a significant burden for issuers that have to re-submit information, and place additional pressure on the timeline for certification. We urge that any data collected by the State should not be re-collected or re-reviewed as part of the QHP certification (whether as part of an SBE or FFE).

In the short term, every effort should be made to avoid duplicative data submissions. It appears that health plans could be required to submit the exact same information to the HHS system, the Health Insurance Oversight System (HIOS) and the state system, the System for Electronic Rate

and Form Filing (SERFF).[1] This will add unnecessary administrative costs. We recommend the exchange not reevaluate state-generated information related to state licensure and documentation of good standing, but simply have the plan attest to these requirements and the Exchange can verify this information with the applicable state regulator. Areas in which we are particularly concerned about the potential for duplication include:

- The upload of letters from state regulators;
- Duplicative review for compliance with essential health benefits (EHB);
- Instances in which a state would request a set of information to review compliance different from that required by the Exchange for QHP certification; and
- The potential for duplicative submissions to SERFF and HIOS due to rate review and 3Rs submission requirements that issuers must meet for all QHPs inside and outside of the Exchange.

We look forward to working with HHS to minimize duplicate data submission as the more detailed requirements and templates are released in the near future.

Iterative Process for Data Submissions

We understand that HHS plans to launch its system for QHP data collection, the Health Insurance Oversight System (HIOS), near the end of March 2013, with QHP submissions due at the end of April 2013. We do not believe this timeline will work, given the need for final rules related to EHBs and actuarial value, the 2014 market rules, and the technical information related to the risk mitigation program. We are particularly concerned about areas where states have until 30 days after the publication of the final rules to make their determination regarding the age curve and the state's rating areas. Given the potential for delays, we recommend that HHS consider a phased approach for the data submission with initial data submitted in April 2013 and the option for plans to submit additional information up until the June timeframe. Health plans may face significant hurdles in condensing data submissions within the proposed timeframe and will need additional time to submit data related to products, rates, rating business rules, and information on networks and essential community providers (ECPs). We look forward to working with you on the development of a specific timeline to provide this additional information in a manner that balances the need for health plans to have additional time to submit with your need to review and certify all of the various QHPs.

Regarding SPEs, documents released by CCIIO and the NAIC propose that all data are submitted through SERFF for the state's review and certification, with HHS having the final authority to certify and ratify the plan. We would like to emphasize the importance of the state's review and the importance of HHS relying on the state decision and not conducting any additional rework or requiring additional submissions for certification. We also request confirmation that the SPEs

[1] See slides and process flows presented at the NAIC's Plan Management Forum VI on November 27, 2012.

submission via SERFF will use the same templates. Given the compressed timeframes we would not support the use of a separate set of forms and spreadsheets to meet SERFF requirements.

Ensure Confidential Data are Protected

Given the broad set of data proposed to be submitted for the QHP certification process and other ACA requirements, it is critical that those submitting data understand how the data will be handled, and other "rules of the road," including how the data will be used and which data will be made available to the public and in what manner. Such "rules" are vital to the success of any data collection effort that involves confidential or proprietary information. Such rules should be clear, fair, and transparent and provide an adequate process for the submitters of data to understand and comment *in advance* regarding any release of confidential or proprietary data. The provision of such protection is one of the purposes of the PRA and is embodied in associated laws, such as the Freedom of Information Act (FOIA) and Trade Secrets Act. These laws recognize the public's interest in accessing certain information, but likewise recognize the importance of protecting confidential information from public disclosure. Such protection provides multiple benefits, including encouraging the submission of useful commercial and financial information and, as recognized by the Federal Trade Commission, preserving the functioning of competitive markets.

To highlight our specific concerns, we note that CMS's "Supporting Statement" indicates that information collected for plan management, reinsurance and risk adjustment "contains proprietary information, trade secret, commercial and/or financial information…therefore it is privileged, private and to the extent permitted by law, and protected from disclosure." While we agree that many of the data should be protected; we are concerned that the supporting statement does not detail how underlying, raw data submitted to the agency (as compared to information to be displayed on the Exchange's website) will be treated and protected from disclosure when such data are confidential.

To resolve this concern, we recommend that the QHP application include a confidentiality template, so that QHP issuers can clearly designate certain information as confidential and thus protected from release under FOIA. In such a template, QHP issuers would designate information as confidential at the data field level, as well as provide a rationale for the proposed designation. Certain categories of information, such as premium base rates and rating business rules as well as the potential for sections of the required Actuarial Memorandum, are so competitively sensitive, and their public disclosure so likely to lead to competitive harm that we recommend that all such information be designated as confidential by CMS and thus protected from release under FOIA. Such information includes: premium base rates and rating business rules as well as the potential for sections of the required Actuarial Memorandum, among other data.

Applicability of Certification Requirements to Stand-alone Dental Plans

We appreciate that only reasonable certification requirements will be applied to stand-alone dental plans. Dental issuers will only be required to complete applicable templates and provide data related to: licensure and good standing, network adequacy, dental-specific out-of-pocket maximum and actuarial value as well as applicable dental benefit information on the plan and benefits template.

We ask CMS to reconsider the requirement that dental issuers comply with the ECP requirements and exclude this requirement for stand-alone dental plans, or at the very least delay the requirement until such time that the need is better defined. We understand that most if not all dentists who provide care in such settings also practice dentistry in private practices. As such, significant portions of the dentists in most areas of the country are under contract with dental plans today. This requirement is not likely to significantly improve the environment that dental patients encounter today and would therefore only create unnecessary work and expenses for dental plans to demonstrate their compliance with the rule. We do not believe commercial dental plans have to date impeded access or the delivery of care to any child seeking dental services – our members are dedicated to providing cost effective dental coverage. We ask that CMS consider this request to help ensure the costs associated with participating on Exchanges will remain within reason and not sacrifice patient access to dentist and proper dental care.

Data Submission – Technical Comments

While we anticipate an ongoing dialogue between health plans and CMS as these data templates are finalized, there are a number of issues related to the data submission process on which we request additional information and technical feedback to allow plans to prepare to submit these templates to ensure timely and accurate submission. We request that CMS provide a timeframe in the immediate future when it will begin regular work group calls similar to existing calls for Healthcare.gov Plan Finder specific to the FFE submission process. We also request that CMS provide multiple training sessions on the submission of the data templates in advance of system's go-live date. If templates are not finalized by this time, we request that CMS provide training on the draft templates, similar to the process used for the Plan Finder, and provide additional guidance once the templates are finalized.

In addition to establishing regular calls and training sessions, we request feedback on the following technical issues to support plan preparations for the submission process:

- *Level of Benefit Templates*: We recommend benefit templates be completed at the state level to show all products and plans available.
- *Data Definitions*: We strongly recommend that data field definitions and templates be released together.

- *Error Codes:* We strongly recommend that error codes be defined and released in advance.
- *Interactions with State Approval Process:* If a plan submits benefits or rate templates for rates/forms that are not yet approved, and the plan must subsequently make a change to the associated or supporting templates, we recommend there is a process in place to make changes to the data templates without going through the entire submission process again.

In addition, we note that data submission process relies heavily on the upload of Excel spreadsheets, but some XML capability will be permitted. We recommend that CMS allow for XML submissions wherever practical and that information on how to test this capability be provided to health plans in early 2013. We recommend that the submission model be closely monitored for technical problems and updated in a timely manner to resolve any submission issues to support a smooth transition process. If the testing demonstrates consistent problems with this submission model, reconsideration of its inclusion should occur. We understand there were extensive issues with XML filings for the federal internet portal healthcare.gov.

Regarding the frequency of data collection, we recommend that the data elements in each of these templates for the individual market need only be submitted once per year. The Supporting Statement indicates that issuers submitting data for the SHOP exchange have the option to submit formulary, rate and benefit information more frequently. We ask that CMS provide additional guidance on the SHOP specific reporting requirements as soon as possible. We propose that carriers operating in the SHOP exchange maintain the flexibility that is in the market today with respect to how often to file for rate changes with state insurance departments. For both the individual market and SHOP, we recommend that issuers need not update CMS with every change. For example, contact and personnel information included in the administrative data elements or formulary changes would be cumbersome updates for a plan to submit with each change. Thus, we recommend that these data templates be submitted annually and represent a snapshot in time at the point of QHP certification.

Submission of Reference Data for Non-QHPs

The Supporting Statement for Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations notes that the ACA reinsurance and risk adjustment programs have general information reporting requirements for non-QHPs in the outside Exchange market. We ask for clarification on the requirement to submit reference data for non-QHPs, including administrative information, rating areas, rating factors and AV level and ask that CMS release data templates for this data submission for comment as soon as possible.

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 QHP Application

QHP Issuer Application Data Requirements (Appendix A.1)

Data Element	Comment
Administrative Data Elements	
3. Associated Health Plan Identifier (HPID)	We request clarification that the HPID will not be a required data element. Appendix A.1 of the QHP Certification PRA lists the "Associated HPID" as an administrative data element to be submitted by issuers as part of the QHP certification application process; however, the SERFF draft administrative data template indicates that the HPID is not a required data element. The Final Rule on the Adoption of a Standard for a Unique Health Plan Identifier states that "the only required use of the HPID is that a covered entity must use an HPID to identify a health plan that has an HPID in the standard transaction." Health plans are concerned that requiring submission of the HPID as part of the QHP certification application would conflict with that final rule and undermine the intention of the HPID as a transactional identifier. Therefore, AHIP recommends that the HPID not be required in the QHP certification application templates for the 2014 plan year and remain optional in subsequent plan years. Health plans are preparing to make HPID enumeration decisions based upon the anticipated use of the identifier. That is, use of the HPID in a certification application may conflict with an

Data Element	Comment
	enumeration decision for the identifier based on use in the standard transactions. In order to make a lasting and meaningful enumeration decisions, health plans need to know all of the anticipated uses of the HPID prior to making such decisions. For the 2014 plan year, making an HPID enumeration decision to support this additional function as part of the QHP certification application would be especially difficult. Per CMS, the HPID enumeration system will not be up and functioning until approximately February 2013. For QHP issuers to submit QHP applications with an HPID for the FFE in April 2013 would be an extremely short timeline if details on data elements or the enumeration system are not available until just prior to application submission. This schedule would leave very little time for QHPs to perform complex organizational analysis and decision-making as to how to they would want to structure their future HPID use.
47 – 51. System Contact	We recommend that plans have the option to submit contact information for additional staff to have access to and be able to submit data into HIOS. As a general note, we recommend an expansion of the ability of additional staff to enter information into HIOS beyond what is currently allowed for Healthcare.gov entries, including updated user rules.
148. Do you have a TPA that currently provides services for the following processes: Enrollment (Y/N), Claims Processing (Y/N), Edge Server (Y/N)?	Please clarify the definition for "Third Party Administrator (TPA)."
State Licensure Documentation	
If license and certificate of authority are not in possession for all	We recommend that the statement "for all service areas" be

Data Element	Comment
service areas, attestation that license and certificate of authority will be obtained and a projected date of obtaining license.	revised to "for all service areas in which the issuer intends to offer a QHP." This revision clarifies that issuers will not be required to be certified to offer plans state-wide and is consistent with attestation #8(4) in Appendix A.2.
Accreditation Data Elements	
2. NCQA template – (d) Accredited product Type(s) 2. NCQA template – (f) HIOS Product ID for Accredited Product 3. URAC template – (f) HIOS Product ID for Accredited Product	Because of differences across accrediting entities, we recommend that accreditation information is initially captured at the issuer level. Therefore, these data fields referencing product types are not necessary and we recommend they are removed.
"On ECP List or Write-In"	We request clarification of the intent for submission of ECP information. Specifically, we understand that CMS will provide a pre-populated list of known ECPs in a state to support identification of ECPs and the contracting process. How will this data be pre-populated? When will this list be available to health plans? How frequently will an updated list be provided? If plans are required to input this data manually the process would be very time intensive. We recommend that, preliminarily, some flexibility is given to ECP standards in the 2014 plan year, while still ensuring that QHP issuers provide adequate coverage in medically underserved areas. This would allow plans to meet the intent of the provisions related to ECPs and meet the needs of enrollees in underserved areas while QHPs issuer's work to contract with ECPs. Many ECPs may not have existing relationships with issuers and may not be accustomed to the contracting and

Data Element	Comment
	technical requirements necessary to participate in a plan's provider network as well as meet electronic claim filing and quality reporting requirements (integral to accreditation). Therefore, both plans and providers may need additional time to include ECPs in provider networks.

QHP Issuer Application Attestations (Appendix A.2)

Data Element	Comment
General	We believe that the number of attestations required in this data template – 93 in total – is excessive and unnecessary. While health plans support attesting to information submitted (e.g., licensure and in good standing), some of the information in the proposed attestations can be independently verified and should not require an attestation. For example, attestations related to EHB and preventative services (e.g., #31-37) can be verified by a review of the health benefit template and the benefit cost-sharing template. Cost-sharing limits (#39) can be verified by a review of the associated templates, etc. We also emphasize the need for each attestation to very clearly state what is being attested to in order to eliminate any ambiguity. We also add that further clarification is needed as to who must submit the attestations. This was a source of significant internal

Data Element	Comment
	effort for plans within a compact timeframe for Healthcare.gov submissions, and we encourage CMS to be as clear and specific as possible in outlining submission requirements to expedite the process for submitting QHP certification applications. In addition, we request additional information as to how attestations for the QHP certification application would need to be submitted for individual market FFE versus FF-SHOP exchange participation. Please clarify whether two applications be needed for each exchange, or if the appropriate information may be submitted through one application (which would require double submission/attestation for each market in several instances to accommodate separate plan/rate information and separate internal staffing). Finally, we also ask that at the time of the data submission, issuers should not be asked to attest to meeting regulatory requirements that are not yet defined.
7. As a QHP issuer, applicant attests that it will notify and obtain HHS approval prior to making any change in ownership that impacts the entity(ies) which directly impact the QHP issuer.	We recommend that HHS prior approval of an ownership change should not be required as this is duplicative of the Insurance Holding Company Act Form A that issuers submit to their state departments of insurance.
10. The applicant (under a current or former name) attests that there are no Federal or State Government past (within 3 years of this submission), current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration against the applicant, its principals,	Health plans may be constantly engaged in various legal actions, ranging from provider disagreements to individual lawsuits and class actions. It would be very difficult to provide supporting documentation and may violate privacy and/or confidentiality to do so. We are also concerned with the reference to

Data Element	Comment
or any of its subcontractors.	"administrative actions," as this could be read to include signed orders within which a carrier has agreed to payment of fines. We recommend that this attestation be removed and that meeting state licensure and good standing requirements should be sufficient.
7. As an issuer of a QHP, the applicant will provide new enrollees an enrollment information package.	We recommend that this be revised to read "the applicant will provide new enrollees access to an enrollment information package." This revision will support health plans that permit enrollees to select to receive enrollee notifications, member materials, etc., in electronic or paperless formats.
20. As a QHP issuer, applicant agrees to provide required notices to enrollees, including enrollment materials consistent with HHS rules, including but not limited to summary of benefits, evidence of coverage, provider directories, enrollment/disenrollment notices, coverage denials, ID cards and other standardized mandated notices.	We recommend that this be revised to "provides access to evidence of coverage and provider directories." This revision supports plans that offer enrollees access to certain member materials electronically or in paperless formats. In addition, some of these documents can be very large and change over time and it may be more reasonable to provide access to them through various formats rather than providing a paper copy to every enrollee to reflect every change.

QHP Benefit and Service Area Data Requirements (Appendix B.1)

Data Element	Comment
Health Benefit Data Elements	
General	We understand that many of these data elements are aligned with the existing data requirements for the Summary of Benefit and Coverage and the Healthcare.gov data templates. However, many require additional clarification as to the precise definition. We recommend additional clarity be provided for many of these terms, but note that changes to the SBC and Heathcare.gov data submission requires additional time for systems updates.
General	The description of data elements in Appendix B.1 indicates for some data elements that the field must be manually populated (e.g., dollar amount entered) and specifies that some fields will be populated from a drop-down menu. However, it is unclear for many data fields how the response will be populated. Please clarify those fields for which a drop –down menu will be available (e.g., data elements with a Y/N answer, or those for which the data entered will be selected from a few options, such as metal level) and those for which a value or explanation must be manually entered.
4. Outpatient Facility Fee 13. Urgent Care Centers or Facilities 15. Emergency Room Services 17. Inpatient Hospital Services (e.g., Hospital Stay) 21. Skilled Nursing Facility 25. Mental/Behavioral Health Inpatient Services 27. Substance Abuse Disorder Inpatient Services	Please clarify whether these only include the facility fee or also include other "ancillary" services associated with the visit, admission, etc. (e.g., labs, tests, supplies, physicians).

Data Element	Comment
5. Outpatient Surgery Physician/Surgical Services	Please clarify whether other specialist services, such as Radiologist, Pathologist, Anesthesiologist, or any supplies associated with surgery should be included.
8. Routine Dental Services (Adult)	Please provide a definition of routine dental services so this can be consistently reported across issuers.
9. Infertility Treatment	In addition to assisted reproductive technology (ART), please clarify whether this should also include the treatment of the underlying condition which is causing the infertility.
14. Home Health Care Services	Please clarify whether this is just the Home Health Care cost share or includes other services that may be rendered in a home health setting (e.g., dialysis, home infusion therapy).
28. Generic Drugs 29. Preferred Brand Drugs 30. Non-Preferred Brand Drugs 31. Specialty Drugs	These drug data elements are for retail only, please clarify whether Home Delivery/Mail Order drugs need to be included as well.
28. Generic Drugs	Please clarify whether plans need to specify if generics are single source or multi source. How would generic drugs that fall under the usual and customary bucket that reflect the chain generic programs be reported on the templates?
29. Preferred Brand Drugs	Please clarify the definition of "preferred." We assume the definition of preferred could vary based on a particular plan design? Are these an issuer's tier 2 drugs minus specialty drugs?
30. Non-Preferred Brand Drugs	Please clarify the definition of "preferred." We assume the definition of preferred could vary based on a particular plan design? Are these an issuer's tier 3 drugs minus specialty drugs?
31. Specialty Drugs	Please clarify the definition of "specialty" and that this applies to the pharmacy benefit only.

Data Element	Comment
32. Outpatient Rehabilitation Services 45. Rehabilitative Speech Therapy 46. Rehabilitative Occupational and Rehabilitative Physical Therapy	Please clarify what is included in each of these benefits. If "Rehabilitative Speech Therapy" and "Rehabilitative Occupational and Rehabilitative Physical Therapy" are provided outpatient, are they included in the "Outpatient Rehabilitation Services" benefit? We note that cost shares will vary by setting (e.g., office visit or outpatient facility) and by type of therapy (e.g., PT/OT/ST, cardiac and pulmonary therapy).
34. Chiropractic Care	Please clarify what is included in this benefit. Specifically, does this refer to services rendered by a chiropractor, which can include physical therapy services or specifically benefits like spinal manipulation? Chiropractic services can be performed in an office or an outpatient facility and it should be clarified whether this benefit includes all outpatient settings.
37. Imaging (CT/PET Scans, MRIs) 49. X-rays and Diagnostic Imaging	Please clarify the distinction between the two benefits. Specifically, we ask for clarity on what is included in the Diagnostic Imaging benefit that would not be included in Imaging. Is #37, Imaging, intended to reflect preventive services only? Does #49, X-rays and Diagnostic Imaging, include diagnostic tests such as hearing, EEG, EKG, etc., or is it only x-ray and imaging tests? We request that the two benefits are described more specifically to provide clarity.
37. Imaging (CT/PET Scans, MRIs)	Please clarify what settings should be reported as various outpatient settings are appropriate.
39. Routine Foot Care	Please clarify what is considered routine foot care and if this is limited to diabetics.
41. Weight Loss Programs	Please clarify whether issuers need to provide data related to clinical programs and discounts. Given discounts are not health

Data Element	Comment
	benefits, but rather discounts we recommend they not be included and this should be limited to health plan weight loss programs.
44. Dental Check-Up for Children 50. Basic Dental Care – Child	Please clarify the distinction between these two benefits and more specifically identify what is included in "Basic Dental Care."
56. Abortion for Which Public Funding is Prohibited	Please clarify whether pharmacy must report emergency contraceptives separately.
57. Transplant	Please clarify whether and how issuers must report data related to Centers of Excellence (COEs). Please clarify whether pharmacy must report transplant drugs separately. Since an issuer may consider transplant drugs specialty, do these need to be separated out from the specialty drug reporting requirements in #31?
58. Accidental Dental	Please clarify what services are considered Accidental Dental (i.e., office visit, x-ray, surgery, or anything associated with the dental accident as services will vary).
60. Allergy Treatment	Please clarify what is included in Allergy Treatment (i.e., office visit, allergy testing, allergy serum, allergy injection). We note that cost-sharing will vary by type of service and provider/setting.
61. Chemotherapy	Please clarify whether this benefit only includes oncolytics or also contemporary products such as anti-emetics. In addition, please clarify whether pharmacy must report on oncology drugs separately. Since an issuer may consider oncology drugs separately, do these need to be separated out

Data Element	Comment
	from the specialty drug reporting requirements in #31? How should chemotherapy drugs covered under medical be reported? Finally, we note that cost-sharing for chemotherapy will vary by the setting (e.g., inpatient, outpatient hospital setting, doctor's office).
65. Infusion Therapy	Please clarify whether this applies to only the act of providing the infusion therapy or also the actual drug being infused.
66. Treatment for Temporomandibular Joint Disorders	Please clarify the level of care included in this benefit as TMJ treatment can also include office visits, x-rays, etc.
Summary of Benefit and Coverage (SBC) Scenario Results Data Elements	
General	We recommend that these data elements be pre-populated from the SBC
Plan Data Elements	
General	We recommend that as many of these data elements as possible be pre-populated from HIOS or other sources.
5. Do you intend to offer this plan on the Exchange, off the Exchange or both?	We recommend the reference to plans offered "off the Exchange" be removed as an option. If a plan is a non-QHP off the Exchange, this QHP Benefit and Service Area data would not need to be submitted.
15. URL for Summary of Benefits of Coverage	Please clarify whether the FFE will be generating an SBC (similar to Healthcare.gov) or if the FFE will be linking to the Plan's SBC.
16. URL for Enrollment Payment	Health plans need additional information about the requirements surrounding the premium payment website and the timing for when the enrollee should be able to make their first payment or set up their billing information via that website.

Data Element	Comment
19. Plan Expiration Date	We would like to further understand CMS' plans regarding this field. Is this referring to an annual plan submission which may only apply to the plan year being submitted (i.e., 2014 plan year) or something else?
42. Expected Utilization for Tier 1	We are unclear what this is referring to.
44. Cost-sharing Reduction Plan Variation	We look forward to working with the Department on ways to reduce the burden of the submission of the various cost-sharing plan variations. While we appreciate the proposal to create an Excel macro to automatically generate plan variations, in our comments on the Notice of Benefit Parameters proposed rule we recommend that QHPs not be required to submit a zero and limited cost-sharing variation for every QHP.
46. Upload required supporting documentation	Please clarify what this refers to.
52. Associated HPID	Please see our earlier comments under Appendix A.1 that this should not be a required data field.
53. Employee choice in SHOP	We note that the option to buy-up a metal level is not currently an option for employers in the Notice of Benefit and Payment Parameters proposed rule.
Pharmacy Benefit Data Elements	
General	We note that early submission of some plan and benefit information is critical for the certification process, but that submission of some data elements alongside the QHP certification application is not critical and may be reasonably delayed. For example, some states are delaying the submission of rating information or data on ECPs. We recommend that pharmacy data is one area that does not need to be submitted immediately and that issuers should have the option for a

Data Element	Comment
	reasonable delay in the submission of these data elements to allow issuers additional time to develop their pharmacy benefits.
19. Formulary URL	We recommend that this be a link to the health plan's URL to allow a member to access and search the formulary through the plan's website.
Drug Data Elements	
3. Prior Authorization Required 4. Step Therapy Required	Prior Authorization and Step Therapy are required data elements for Part D benefit submissions; however, we note that it may not always be appropriate to have a commercial model that reflects the Part D model. It is our understanding that CMS intends for this plan benefit information to be submitted annually. If these data elements are to be required, we recommend that this submission be considered a "snapshot in time." Pharmacy benefits change frequently and we recommend that issuers not be required to keep any prior authorization or step therapy designations as static requirements throughout the plan year should not be required to submit updated data for every change in pharmacy benefits.
Service Area Data Elements	
List of data elements to define a plan's geographic service area.	We note that a plan's service area will be defined through state-licensure and does not need to be re-reviewed by the Exchange. This information should be limited to that information necessary to drive the rating engine on the exchange website. We also note that service areas may not align with a state's rating areas and that a QHP may only serve a partial rating area.
7. Partial County Exceptions Narrative – Provide a narrative to justify a request to serve a partial county.	Section 155.1055 of the Exchange final rule requires that the service area of a QHP is, at minimum, the entire geographic area

Data Element	Comment
	of a county unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of qualified individuals and employers, which mirrors the Medicare Advantage "county integrity rule" (42 CFR 422.2). We note that, based on plan experience, application of this rule in Medicare has at times been problematic due to a lack of clear guidelines for how CMS will evaluate plan justification for a partial county service area. We request that CMS communicate clearly to health plans how a justification for a partial county exception will be evaluated, including "in the best interest of qualified individuals and employers," to ensure consistent application of this rule.

QHP Rating Tables and Issuer Business Rules Data Requirements (Appendix C.1)

Data Element	Preliminary Comment
Rating Table Data Elements	
Family Tiers	We support the single age band for children in conjunction with a policy to remove the cap on only counting the three oldest family members under 21 years old when calculating family premiums. The proposed cap represents a significant change from practices for calculating family premiums in the market today. In the group market, family tier structures are common and they generally permit counting of the spouse in addition to a set

Data Element	Preliminary Comment
	number of dependent children. In the individual market, however, all family members (both parents, if applicable, and all dependent children) are counted. The proposed cap would be a dramatic departure from current rating practices. We believe that the current cap should be removed and, instead, CMS should adopt a method similar to the household count under the federal guidelines. Please see AHIP's comments on the Market Rules NPRM for additional details. In addition, we recommend that the rating table data elements be updated to reflect the approach in the Market Rules NPRM whereby composite rates are allowed only for states that choose pure community rating and do not use age or tobacco as rating variables (e.g., New York).
Issuer Business Rules Data Elements	
General	These business rules are used for Healthcare.gov and are not generally consistent with the NPRM on Market Rules. For example Business rules, 5-12 would only apply to composite rating states. We recommend these business rules be updated to reflect the Market Rules NPRM.
12. How is age determined for rating and eligibility purposes?	This business rule is not consistent with §147.102(a)(1)(iii) of the Market Rules NPRM, which states that age is determined at issuance and renewal.
13. How is tobacco status determined for subscribers and dependents?	We recommend that tobacco use is determined by the Exchange to ensure consistency across issuers and tobacco status is based off of the last date of tobacco use.