Submitted electronically via OIRA_submission@omb.eop.gov

December 18, 2015

Re: CMS–10433 Initial Plan Data Collection to Support QHP Certification and Other Financial Management and Exchange Operations

Dear Sir or Madam:

UnitedHealthcare appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with our comments in response to CMS' Initial Plan Data Collection to Support QHP Certification and Other Financial Management and Exchange Operations.

UnitedHealthcare, a division of UnitedHealth Group, is dedicated to helping people nationwide live healthier lives by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. The company offers the full spectrum of health benefit programs for individuals, employers, military service members, retirees and their families, and Medicare and Medicaid beneficiaries, and contracts directly with more than 850,000 physicians and care professionals, and 6,000 hospitals and other care facilities nationwide.

In addition to the comments that we provided on October 2, 2015 in response to the first comment period related to the 2017 QHP templates, we offer the following additional recommendations.

Supporting Template Automation

CMS should provide support for issuers seeking to automate template completion. As an example, limiting the use of underlying macros will allow issuers to streamline the completion of the templates and reduce administrative burdens without affecting the standard allowed responses that eliminate variability in responses by issuers.

UnitedHealthcare also suggests that CMS provide the opportunity for issuers to test automated files with CMS technical staff or a separate testing environment that mirrors template validation in advance of the application filing window to determine if the files will process properly through the CMS hub validation process and other review tools without issue. The testing of automated files should not reduce the window of time that issuers currently have to complete files from the time final templates are released.

Combined Network Adequacy and Essential Community Providers (ECP) Template

With respect to the new data field to capture the number of contracted MDs, DOs, PAs, and NPs authorized to treat and prescribe within listed facilities, we understand the intention of counting

the number of providers at an ECP location, but we have concerns that the information request does not align standard contracting processes. Many of the ECP provider types are contracted at a facility level, and while we have access to the providers at those facilities, we do not hold individual contacts with each of the providers. Thus, measuring issuers' ECP adequacy based upon the number of contracted providers at a location would not accurately reflect provider availability. UnitedHealthcare recommends that measurement be done at the facility level instead of calculating against contracted provider counts.

Additional information is requested regarding the functionality of the planned embedded ECP provider list within the template. At this point, it does not appear as though there is an ability to determine whether an ECP provider is an individual or a facility, and we request that CMS include search functionality, such as first name and last name searches, to facilitate the selection of specific ECPs.

Plan and Benefits Template

UnitedHealthcare agrees with the approach of matching the level of detail in the Plan and Benefits Template with that in the Prescription Drug Template since the data in the Plan and Benefits Template is typically the data displayed to consumers on healthcare.gov. However, given the proposed changes to the Prescription Drug template eliminating the section where issuers can describe how prescription drug tiering structure works, it is unclear how consumers will be aware of tiering when they select a plan to enroll in during open enrollment. We request that CMS provides additional information regarding the need, if any, to provide additional notes that describe a plan's prescription drug benefits in the Plan and Benefits template to ensure that consumers have all the necessary plan information available to them when making a plan decision. For example, if issuers need to provide additional notes regarding formulary tiers or mail order in the Plan and Benefits Template so it will display on healthcare.gov, CMS needs to provide issuers with detailed instructions regarding the expected information with as much advance notice as possible before the start of the application window.

The most recent version of the Plan and Benefits template includes a proposed change related to Mental Health Emergency Services. In the Cost Share Variance tab there is a symbol noting that the change would not be implemented for Plan Year 2017 but will be included for Plan Year 2018. However, the symbol is not present on the Benefits Package tab. We request clarification whether this change will be implemented for Plan Year 2017 or 2018.

UnitedHealthcare also suggests adding minimum and maximum fields for employer's HSA/HRA contributions. While the Actuarial Value Calculator can currently only handle one value, the Plan and Benefits Template is also used to populate display information that is used in the Actuarial Value Calculator. We believe that the additional detail of seeing the contribution range will be valuable for employers so they do not inadvertently make a contribution that would deem the plan non-compliant with the filed and approved metal level.

Prescription Drug Formulary Template

We request clarification whether one line per formulary ID is expected in the Prescription Drug Formulary template. Additionally, we seek clarification on where information regarding mail order benefits will be collected for display on healthcare.gov.

Business Rules Template

It does not appear that the Business Rules Template was changed in relation to the Supreme Court ruling on same-sex marriage. We request clarification in the instructions for the Business Rules Template if there are any modifications as a result of the ruling to how issuers should complete the template related to questions regarding secondary subscribers.

Within the Business Rules Template instructions, CMS should include definitions for what is meant by each dependent category. Issuers have to identify whether they will allow certain dependent types for enrollments, but there are no clear definitions for what is included in each category. The dependent categories found in the Business Rules Template are the same options used in the 834 files; however, we are also unable to find substantive definitions in the 834 guidance. Without category definitions, some of the terms appear to refer to the subscriber or spouse instead of the dependent classification, such as "guardian" instead of "dependent under legal guardianship." If more clear references to the dependent classifications and definitions are not provided, this may lead to variations in how issuers interpret the terms, especially when terminology varies within state requirements related to mandated dependent coverage, and it may lead to an inaccurate representation for the consumer.

UnitedHealthcare urges CMS to change the template for Plan Year 2017 to capture age requirements for grandchildren and dependents of minor dependents. Without such edits, the Marketplace cannot appropriately vet that the enrollment presented is truly eligible for enrollment. For example, the current dependent rules information collected would allow a 30 year old grandchild to be enrolled as a dependent. The current structure allows selection to occur, which may result in increased premium costs.

We would also request that CMS consider removing dependent categories from the Business Rules Template that are not supported by the Exchange enrollment process. This would help reduce the collection of unnecessary information and the resulting administrative burden of completing the template.

QHP Timeline Challenges

As we have stated previously, issuers require as much advance notice as possible before the opening of the QHP submission window to work with updated templates and understand any new requirements. We request that CMS release the final 2017 templates and template instructions as soon as possible. Additionally, CMS should provide examples and opportunities to test functionality before the filing window.

Thank you for your consideration of our comments.

Sincerely,

Heather Kane

Heather Kane
CEO, Public Exchange Marketplace
UnitedHealthcare E&I

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

October 2, 2015

Re: CMS–10433 Initial Plan Data Collection to Support QHP Certification and Other Financial Management and Exchange Operations

Dear Sir or Madam:

UnitedHealthcare appreciates the opportunity to provide the Centers for Medicare & Medicaid Services (CMS) our comments in response to CMS' Initial Plan Data Collection to Support QHP Certification and Other Financial Management and Exchange Operations.

UnitedHealthcare, a division of UnitedHealth Group, is dedicated to making our nation's health care system work better. Our core strengths are in care management, health information and technology. Recognized as America's most innovative company in our industry by *Fortune* magazine, we bring innovative health care to scale to help create a modern health care system that is more assessable, affordable and personalized for all Americans.
Below please find our specific recommendations.

Administrative Data Template

Even though there are no changes proposed to the Administrative Data Template, we suggest that CMS revisit the fields in the template against what is also provided by issuers in the HIOS Marketplace Issuer Data Fields in HIOS Plan Finder. We believe there are opportunities to limit duplicative data collections regarding these elements. For example, we recommend that CMS continue to simplify the approach to collecting information via HIOS and the templates, so there is not duplication and it is more clear which customer service data is displayed from each source.

Essential Community Providers (ECP) Template

CMS has proposed a new data field to capture the number of contracted MDs, DOs, PAs, and NPs authorized to treat and prescribe within listed facilities. This information may change frequently, and a point in time summary during the QHP Application process may have limited utility. Since that information has been proposed as part of the new ECP Provider Petition, we recommend that CMS rely on the data provided in the ECP Provider Petition and not adopt the proposal to add this new field to the ECP Template.

We would also like to offer some comments regarding the ECP List that is used to complete the ECP template. As we recently noted in a separate comment opportunity specific to ECPs, some

states require issuers to report 340B participation and Health Professional Shortage Area (HPSA) as part of State-based requirements. Currently, this data is not displayed on the ECP List, but new fields in the proposed future ECP Provider Petition require that this information be captured. Since this information will be collected from ECP providers petitioning HHS, we recommend that the 340B and HPSA fields also be reflected on the ECP List to facilitate QHP issuers' compliance with state reporting requirements. We suggest that whenever the ECP List is updated by CMS that the ECP Review Tool also be updated at the same time so that data is consistent.

Finally, we recommend that the ECP Template and ECP Tool have formulas updated to accommodate for multiple rows if name or NPI is the same for multiple locations of the same provider on the ECP list. Instructions should also be updated accordingly to provide issuers with clear guidance on how to address duplicate providers with multiple addresses but a single NPI.

Plan and Benefits Template

We request additional information on several of the proposed new fields:

- Regarding the proposed "plan design type" field, we would appreciate more information regarding the definition of this field in relation to "plan type" and the drop down options to better understand the information that will be provided in this section.
- Similarly, we need more information to better understand the "Which benefits begin cost sharing after set of visits?" and "Which benefits begin deductible/coinsurance after set copays?", and whether these will be free-form fields or drop down menus.
- Regarding the "Care Plan Limit" column, we need more information on how and when this field will be used and if it is limited to specific benefits. We request that CMS provide drop down options, definitions and detailed instructions to ensure that this field is used consistently across issuers.
- Regarding the Plan Marketing Name field, we recommend that this be an editable field once it is populated when the cost share tab is created.

As a general rule, we support changes to the Plan and Benefits Template and the Prescription Drug Template to reduce duplicative data collection and allow for more detailed, accurate descriptions of plan benefits. Today, in circumstances where the two templates have included varying levels of detail regarding prescription drug benefits, we have seen examples where the benefit and plan design details are not as accurately reflected for consumers on healthcare.gov. With the proposed move of cost sharing information from the Prescription Drug Template Formulary Tiers tab to the Plan & Benefits Template, we are concerned because the drug type in the Plans & Benefits Template is not a 1:1 match to the drug type in the Prescription Drug Template, as illustrated below.

Tiers Available in the Prescription Drug Template	Drug Type(s) in the Prescription Drug Template (each Tier can have more than one drug type)	Drug Types Available in the Prescription Drug Template
Tier 1		Generic
Tier 2		Preferred Generic
Tier 3		Non-Preferred Generic
Tier 4		Brand
Tier 5		Preferred Brand
Tier 6		Non-Preferred Brand
Tier 7		Specialty Drugs
		Zero Cost Share Preventive Drugs
		Medical Service Drugs

Tiers Available in the Plans and Benefits Template	Drug Type(s) in the Plans and Benefit Template (each Tier can have only 1 drug type)	Drug Types Available in the Prescription Drug Template
Tier 1		Generic
Tier 2		Preferred Generic
Tier 3		Brand
Tier 4		Non-Preferred Brand

We recommend that CMS organize the Plans and Benefits Template so it uses the same drug types that are used as are currently in the Prescription Drug Template, or that CMS use the data in the Prescription Drug Template to populate healthcare.gov, so consumers have the most accurate information available when choosing a plan.

We also recommend moving away from a categorical approach to tiering (e.g. generic, preferred brand…) and move to a numerical approach (e.g. Tier 1, 2, 3…) since many carriers do not tier drugs in a categorical manner and may have generics , brands, and specialty drugs spread across also benefit tiers.

UnitedHealthcare would support this change if it enables the Plans and Benefits Template to more accurately reflect the true nature of pharmacy benefits and the associated cost share tiers (e.g. not all generics and specialty drugs are in the same tier). Due to the large variation in cost between specialty and non-specialty drugs, these prescription drug tiers may have two sets of co-payments per Tier. While the SBC presents both cost sharing levels in each tier, we are concerned that Exchange website plan summary information will only display one co-payment per tier. While we usually display the higher co-payment if only one can be displayed so consumers will not be surprised by a higher bill, we are concerned that the higher co-payment is not representative of the majority of drugs in that tier and therefore can lead to consumer misunderstanding and confusion. If all issuers do not use a consistent approach with how they display non-specialty versus specialty co-payments, it could make it difficult for consumers to accurately compare their options across plans. We are interested in a consistent approach between issuers that represents the non-specialty and specialty drug co-payments most clearly for the consumer. If it is not possible to display both non-specialty and specialty drug co-payments for each tier, we recommend displaying the non-specialty drug copayments for each tier since only 1-2% of prescription drug utilization is for specialty drugs. We suggest including a note in

an explanation field, such as: "co-payments for specialty drugs may be higher; please refer to the SBC for more details".

We suggest that CMS add additional fields so that both the minimum and maximum values for the Employer's Contribution for HRAs/HSAs are captured.

We suggest the addition of a Mental Health and Substance Abuse Outpatient Other category be added.

We ask that the Plan and Benefits Template be consistent with any upcoming changes made to the Actuarial Value Calculator.

We also suggest that CMS provide additional information at the beginning of the QHP Application process regarding what is considered to be discriminatory and how the assessments are made so issuers can address these proactively in their submissions instead of waiting until objections are received.

Finally, following the submission of the information on the Plan and Benefits Template, and as a part of CMS's review, issuers may receive a notice of a potentially discriminatory benefit. Along with information regarding the 2017 QHP templates and application process, we request that CMS provide additional details regarding their benefit analysis and the outlier test so issuers can better understand how to design their benefits to limit these types of notices during the review process.

Prescription Drug Formulary Template

We request specific definitions of terms related to the proposed "Quantity Limits" and "Fill Limits" fields be added to the Drugs List Tab. We suggest that CMS define whether quantity duration limits (number of doses per month), quantity level limits (number of doses per copay), and other supply limits (number of prescription fills per year) are included in one or both categories. Since many of these limits are put in place due to safety concerns, we would like to better understand how CMS will take this information into account in the review of QHP applications and how it may be displayed for consumers.

With the proposed "Pharmacy Restrictions" field on the Drugs List Tab, we request clarification on exactly what would be considered a pharmacy restriction. This term also needs to be clearly defined, as there are many types of optional and required pharmacy programs that may or may not be included in the definition, including programs to help members on select high-cost medications save money, mail order programs, and network pharmacy programs. Additionally, there are non-issuer specific pharmacy programs, including when pharmaceutical manufacturers may choose to limit the distribution of a drug to a limited number of pharmacies, and the Food and Drug Administration may also limit the distribution of a drug as part of the approval process. Similar to above, we would like to better understand how CMS will take this information into account in the review of QHP applications and how it may be displayed for consumers. Additionally, we request information on how proposed changes for 1/1/2017 requiring access through physical, retail pharmacies may affect the use of this field.

Regarding the proposed addition of an "Over-the-Counter (OTC) Step Therapy Protocol" field to the Drugs List Tab, we would like to confirm whether the parameters for this field will take into account that many QHPs utilize a P&T committee that is responsible for approving the clinically appropriate use of step therapy program. Additionally, we would like for CMS to articulate whether this field would only apply to step therapy programs where all agents in the step protocol are OTC, or if it also applies in the case where there may be both OTC and prescription agents in the step protocol.

Business Rules Template

While no changes are currently proposed to be business rules template, we would like to raise a concern with the template as it exists today.

Within the Business Rules Template, CMS should include definitions for what is meant by each dependent category. Issuers have to identify whether they will allow certain dependent types for enrollments, but there are no clear definitions for what is included in each category. Without category definitions, some of the terms appear to refer to the subscriber or spouse instead of the dependent classification, such as "guardian" instead of "dependent under legal guardianship." If more clear references to the dependent classifications and definitions are not provided, this may lead to variations in how issuers interpret the terms, especially when terminology varies within state requirements related to mandated dependent coverage, and it may lead to an inaccurate representation for the consumer.

The current version of the template does not allow issuers to specify restrictions on certain dependent relationships, such as maximum age or marital status of a grandchild. If we select that grandchildren are covered, then all grandchildren will be allowed to enroll on healthcare.gov, regardless of the parameters that are required by the state or included in issuers' policies. We suggest that there be additional flexibility in the Business Rules Template for issuers to set age requirements for grandchildren and dependents of minor dependents.

Similarly, additional restrictions should be accommodated on the template for partnership situations. If issuers cover Registered Domestic Partners, they must select "Life Partner" on the template. The Life Partner category is a broader relationship category than many issuers may typically offer coverage, which includes unmarried partnership relationships of any type.

Network Adequacy Template

With the proposed new data field for "Provider Cost Sharing", we urge CMS to clarify that this data field reflects a member's cost-share and confirm how this information will be used in the QHP application process.

Data Integrity Tool

CMS should have the DIT tool provide more detailed error information, so issuers can better address concerns and how to correct errors. We recommend that CMS align the validation checks within the DIT tool and the HIOS portal. For example, an error message of "Actuarial Value Mismatch" was given for "Cost_Share_Variances_1-A.15" when A.10 contained the error.

QHP Application Process

We recommend that CMS provide issuers with the opportunity to review, but not necessarily have the ability to change, the QHP Application in HIOS at any point. Within SERFF, issuers are allowed to view the contents of their filed binder at any time. This is helpful to validate questions internally as they come up throughout the year as issuers are able to confirm the latest version of a document submitted for review. Issuers are only allowed to update their SERFF binders when the binder is in a certain status or if the state has reopened a closed binder. It would be helpful to have the same capability within HIOS where issuers can review the contents of their QHP Application at any time but only can make changes when CMS has provided that opportunity within the system.

QHP Timeline Challenges

Issuers require as much advance notice as possible before the opening of the QHP submission window to work with updated templates and understand any new requirements. When final guidance is released late in the cycle, this leads to rework by issuers, states and CMS, as well as a reliance on ad hoc, unwritten guidance. As a general rule, we recommend that CMS release the final FFM Issuer Letter, QHP Templates and all related tools, including the Master Review Tool and Data Integrity Tool at least five months before the start of the QHP submission window. For the 2016 plan year, we ask that the final versions be released by December 1, 2015.

Thank you for your consideration of our comments.

Sincerely,

Heather Kane
CEO, Public Exchange Marketplace
UnitedHealthcare E&I