# QHP PRA Summary of Comment and Response

| Summary of Comment | CCIIO Response |
|---|---|
| Recommend HHS encourage SBEs to use the same templates for uniformity | HHS will continue to encourage SBEs to use our proposed data collection templates but cannot require SBEs to use the same templates. |
| Recommend HHS data collection is consistent with state requirements and avoid duplication, re-collection, or re-review. Leverage exiting reporting processes to facilitate consistency for states and consumers and workable processes for issuers in advance of next year. | HHS has created a process to ensure that regulatory reviews conducted by engaged States will not be duplicated by HHS. In the first year, there still may be a requirement to submit to both systems where electronic processes do not allow a single submission. Further improvements will be made electronically in future years for all engaged States. |
| Recommend HHS not conduct additional rework or require additional submissions for certification of SPEs and require SPEs to use same data collection templates. | While the law does not allow HHS to completely delegate QHP certification to states with an FFE, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS. Specifically, HHS will accept or respond to state QHP recommendations, on the condition that the state has followed processes previously outlined in the Blueprint application and MOU agreement. HHS does not intend to re-review QHP data or otherwise duplicate work performed by the state. HHS will notify the state in writing of any concerns that preclude HHS approval of its recommendations; the state will have an opportunity to respond to HHS's concerns and request reconsideration of HHS's decisions. HHS will notify the state of its final decision and basis for the decisions. |

# QHP PRA Summary of Comment and Response

| Summary of Comment | CCIIO Response |
|---|---|
| *Since State Based Exchanges (SBEs) are not required to use these templates, we would suggest that the templates be made as independent as possible. New York should have the option to utilize the Service Area Templates, Network Template and Essential Community Provider Template.<br>*How will HHS support variations to the templates for SBEs? | The templates will be made available to SBE's to use or modify as they prefer. SBE's are free to use some or all of the templates; cross-functionality may be lost of the SBE does not use all of the templates. |
| Urge CMS to require state review and approval prior to submitting QHPs for certification in future years. The concurrent state-federal review processes envisioned could delay products from being certified and offered on exchanges. Avoid multiple submissions of data templates if possible. | HHS will continue to work with states and issuers to revisit the timeline for future years. |
| Uncertainty around timing of final rules and impact on data collection. Recommend HHS consider phased approach for data submission through June given the timing of final rule publication and state decisions (e.g., 2014 market rules plus 30-day state determination regarding age curve and rating area) | HHS has developed its timeline and templates to accommodate publication of final rules. For the rating templates validations will make sure that the age 64 and over rate is not more than 3 times the age 21 rate, but not specifically to the curve. |
| Recommend that application include a confidentiality template so that QHP issuers can designate certain information as confidential and thus protected from release under FOIA (e.g., premium base rates, rating business rules, and actuarial memorandum) | Such a template is not necessary because proprietary business information is protected under FOIA |
| Reconsider requirement that dental issuers comply with ECP requirements | The PRA does not address the issue of whether or how SADPs will be required to meet ECP standards. |
| BCBSA supports the Stand-Alone Dental Plan Information Collection. An explanation of the methodology for the APTC calculation is needed as soon as possible to complete plan design and pricing. | Please see the Proposed HHS Notice of Benefit and Payment Parameters for a discussion of the methodology for the APTC calculation. |
| Summary of Comment | CCIIO Response |

| | |
|---|---|
| Identified applicability by appendix and section for the extent to which data elements apply to stand-alone dental plans. | We appreciate the mapping and will consider these comments when setting requirements in the FFE. |
| Recommend (and request timeframe for) regular calls and training sessions regarding the submission process, timing, draft and final templates, data definitions, error codes, interactions with states, resubmissions and corrections, data reuse and pre-population, display to consumers, review standards (e.g., network adequacy), testing | Several commenters recommended that CMS conduct outreach and education activities in preparation for the exchanges.<br><br>We agree with the commenters and are presently engaged in tailored issuer outreach activities and technical assistance. We [released/will release] video tutorials to allow issuers and other stakeholders the flexibility to participate at their own schedule. Additional upcoming activities consist of weekly webinars, new tutorials and onsite conferences in the spring. The topics include data collection requirements, draft and final templates, timelines and resubmissions, network adequacy and other relevant areas on policy and operational guidance for operating exchange and market stabilization programs. We will invite all issuers and other stakeholders to participate and will continue to release sub-regulatory guidance. |
| Recommend data templates be submitted annually and represent a snapshot for individual market, including formulary data. Request additional information on SHOP specific reporting. | We will consider these comments when setting requirements in the FFE and will provide additional information in the future regarding SHOP reporting. |
| Request additional information on reporting requirements for non-QHPs in outside Exchange markets. Request for published templates. Information for reinsurance and risk adjustment information is presumed to be required within a separate template that would collect the data listed in Appendix D of the PRA notice, but it is unclear if a state does not use the CMS benefit template and SERFF upgrade how this information would be collected. | HHS will provide a template for submission of non-QHP data. The non-QHP data template will be similar to the QHP certification application templates. HHS will collaborate with States to obtain non-QHP data when possible. HHS will provide future technical guidance for the method of collection. |
| Summary of Comment | CCIIO Response |
| | HHS will define the data fields in technical guidance released |

| | |
|---|---|
| *HPID - required or optional, clarification around definition<br>*System contact - recommend option to submit information for additional staff, i.e., expansion of what is currently allowed<br>*TPA - clarification regarding definition | in the near future. |
| Revise language 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. | HHS will make the clarification where appropriate. |
| Recommend that accreditation information is initially captured at the issuer level. Data fields referencing product types are not necessary and recommend they are removed. CMS should clarify if and how this information would be displayed to the public. | HHS plans to display accreditation status at the issuer level. However HHS needs to collect accreditation data at the product level to accurately link CAHPS data from existing commercial/Medicaid accreditation, administered at the product level, to QHP product types for display on the Exchange internet web sites. |
| Clarification of the intent for submission of ECP information. How will this data be pre-populated? When will this list be available to health plans? How frequently will an updated list be provided? Consider a phased approach. | CMS expects to publish a list of ECPs in the next several weeks. The initial list of ECPs should be viewed as a resource for issuers, rather than an exhaustive list, and will not be updated before issuers submit QHP applications. With respect to the comment about a phased approach, we note that issuers that fail to achieve CMS' targets for ECP inclusion can submit a justification explaining how their networks provide access to care for all enrollees. Issuers that provide adequate justifications and meet all other standards should not have trouble obtaining certification for QHPs. |
| Summary of Comment | CCIIO Response |

| | |
|---|---|
| Concerned that the proposed data collection will impose a heavier burden on integrated care delivery systems than is justified by the need for or usefulness of the information collected. | Issuers that represent integrated delivery systems must demonstrate that their provider networks include a sufficient number of ECPs. CMS does not believe that this reporting requirement places an undue burden on these issuers. CMS will publish a list of HPSA and lower-income zip codes; integrated issuers will only be required to provide information on their own providers in or adjacent to those zip codes. CMS believes that this data collection is necessary to ensure that enrollees in integrated plans have adequate access to providers, and such issuers will be able to provide explanations if they are not able to achieve CMS targets. |
| Reduce the number of attestations and avoid duplicative attestations. Further clarification is needed as to who must submit the attestations, and clarification whether two applications are needed for each exchange - SHOP and individual. | HHS has reduced the number of attestations to address duplication. HHS will define the specific person who will attest and that only one attestation needed for SHOP and the individual market. |
| *Additional clarification, definitions, and fields descriptions are requested regarding the list of benefit services, plan data elements, and supporting documentation.<br>*Inconsistencies Related to Benefits and AV Calculator: The Plan Benefits Template contains 56 non-EHB benefit categories and the AV calculator has 18 categories, Appendix B.1 of the PRA Notice lists 70 health benefit data elements, while the Plan Benefits Template lists 55 benefit services. Do not build AVC in benefits template or ensure that data elements directly crosswalk. | HHS will define the data fields in technical guidance released in the near future. Additionally, the benefit services are defined by each state-specific benchmark plan and may vary by state. HHS will ensure that the data collection and templates align and that the correct benefits are pulled from the template for the AVC. |
| Recommend adding data elements to the collection, including benefits to the list to capture cost sharing, additional limit units, multiple limits, and out of network reimbursement methodology. | HHS developed the data collection to balance burden on issuers and need to support exchange and federal operations. |
| Recommend pre-population from the SBC | HHS has developed functionality to pre-populate the SBC. |
| Summary of Comment | CCIIO Response |

| | |
|---|---|
| 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. | This option for a QHP issuer to denote a plan as a "buy-up" plan corresponds to a policy proposed in a seprate rule. This data will only be collected if this policy is implemented. |
| Defined through state-licensure and does not need to be re-reviewed by the Exchange, should be limited to that information necessary to drive the rating engine on the exchange website; communicate clearly to health plans how a justification for a partial county exception will be evaluated | HHS will not re-review the license issued by the State. HHS intends to use the license to meet ACA requirement that all issuers in an Exchange by licensed; as well as verify service area |
| *AHIP recommends updating 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).<br>*Make age field optional. | The approach in the Market Rules NPRM will be utilized as indicated, but because the templates are to be used for both composite- and individual-rated States, both options will be made available. This also provides the reasoning behind requiring the age field. |
| *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. | HHS appreciates the comment, but while this may be a change from current practice, our PRA and any subsequent collection must remain consistent with legislation, which requires the cap on the three oldest family members under 21 in calculating family premiums. |
| BCBSA recommend that the family rating rules take the three oldest dependent children who are under age 21 into account in computing the family premium. We appreciate the use of the term “dependent” in describing the business rules data elements and urge this to be clarified in the NPRM. | HHS believes that this is a fair representation of intent and a reasonable solution. |
| Summary of Comment | CCIIO Response |
| | These recommendations and clarifications are helpful and appreciated. The specifics on age and tobacco use |

| | |
|---|---|
| Update to reflect the Market Rules NPRM.<br>*How is age determined for rating and eligibility purposes? [Market Rules NPRM states that age is determined at issuance and renewal.]<br>*How is tobacco status determined for subscribers and dependents? [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.] | determinations will be provided via guidance and are subject to finalization in the final rule for the Market Rules regulation. |
| *Allow states to use 5-digit zip codes in creating rating areas.<br>*Consider asking issuers for justifications as to why an issuer is not serving an entire rating area if the rating area in a state is larger than the service area to minimize gaming by niche health plans | Though we note your comment regarding rating area and will take it into consideration in the future, until those sorts of policy decisions are made, this is not a PRA issue. We will revisit the collection implications when necessary. |
| It is unclear if the Rates Template takes into account that the Exchange may want the rates for riders separately listed. New York may require benefit riders be issued with the rates for such riders | The HHS approach is that a plan includes any riders that accompany it. For example, if a plan is including a rider to reach a certain benefit level, that rider must be rolled into the plan's premium. |
| HHS should provide a good faith compliance period given the inadequate comment periods on the proposed rules, lack of detailed operational specifications and compressed implementation timeframes. | While HHS cannot waive the application of laws and regulations, HHS is making every effort to set certification standards in the FFE to balance the need to protect consumers with giving issuers time to adjust to the new market environment. |
| *Ensure issuers can use automated processes to populate information into the templates<br>*XML format and not Excel/XLS, clarify transmission specifications and provide an estimate on when the specifications would be available as soon as possible | HHS will release data models in technical guidance released in the near future. For year one, the strategy is to have all the data be submitted via Excel templates. After data is validated using the built-in macros, the data is converted to XML, when the final submission is made to HIOS. There are no current plans at this time to provide additional functionality for direct XML submissions by Issuers. |
| Summary of Comment | CCIIO Response |
| *CMS should revise the estimated burden on QHP issuers. Concern that CMS | The burden was developed based on CMS' experience collecting similar categories of data from issuers in the MA |

| | |
|---|---|
| is underestimating the number of QHP filings each issuer will submit and the hours estimated per submission.<br>*Proposed data request is excessive and overly burdensome within existing timeframes unless requirements are streamlined and the data requests and processes are further clarified. | and Part D programs, Federal Rate Review Program, and HC.gov. We have worked with industry to streamline the data collection and believe that the estimates accurately reflect the burden. |
| The level of detail requested for formulary tiers and classes is too extensive and would be burdensome for plans and HHS to collect, load, maintain and displayed data accurately. An alternative option is to t provide a link to the plan's website, at least for the initial years. | HHS developed the data collection to balance burden on issuers and need to support exchange and federal operations. We have worked with states and industry to streamline the data collection. |
| Recommend that separate rating tables, issuer business rules, and rate review data elements are developed for SADPs because they are excepted benefits. | CCIIO will modify the data collection, as appropriate, to accommodate SADPs. |