Comment Type	Commenter	Summary of Comment	Accept or Deny
Cost-sharing data elements	AHIP, Access Health CT	Template should allow issuers to create a separate marketing name for each CSR plan variation	Considering
Cost-sharing data elements	AHIP	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.	Considering
Cost-sharing data elements	AHIP, Access Health CT, KP	The template should allow issuers to tie SBC URLs to all plans, including silver plan variations, not just base plans.	Considering

Cost-sharing data elements	AHIP	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.	Considering
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: Plan Cost Sharing Attributes -- "Explanation (text field)", clarify the intent of this field.	Accept
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: HSA/HRA Detail-- "HSA Eligible", "HSA/HRA Employer Contribution", "HSA/HRA Employer Contribution Amount", confirm that the intent of moving these fields from the Benefits Package Tab to the Cost Share Variances Tab is to allow for flexibility in providing this type of benefit program for the Standard Plan level and allowing other plan variant levels (e.g., Zero Cost Sharing or Limited Cost Sharing) to be excluded from an HRA/HSA program.	Considering
Cost-sharing data elements	BCBSA	Modify the Cost Sharing Variance worksheet to include “Not Covered” as an option for the cost-sharing amount	Considering
Cost-sharing data elements	BCBSA, AHIP	Modify the Plan and Benefits template to permit tiering at the benefit level, rather than displaying all the benefits as tiered if tiering is selected at the Plan level. If CMS intends to continue with having tiering at the Plan level, BCBSA recommends that CMS program the Plan Compare to suppress template data for the second tier if a Plan demonstrates there is only one tier for a benefit.	Considering

Cost-sharing data elements	AHIP	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.	Partially Accept
Cost-sharing data elements	BCBSA	Allow Plans to create only the cost sharing variation for American Indians and Alaskan Natives (AI/AN) under 300% of the federal poverty level (FPL) at the Bronze level when there is no difference in covered services or network. CMS should also allow Plans to not generate HSA plans when they do not meet QHP standards	Partially Accept
Cost-sharing data elements	BCBSA, KP	Amend the template to ask whether non-emergency care is covered out-of-network. If the Plan does not cover the benefit out-of-network, the Plan should be able to enter not covered and not be required to continue to populate with 100% coinsurance or no-charge	Accept
Cost-sharing data elements	KP	Create a fix around only being able to identify the base plans Health Savings Account (HSA) qualified when the CSRs associated were not.	Considering
Cost-sharing data elements	KP	The AV in the Plan and Benefit template should match exactly to the one we get in the AV calculator,	Accept

Cost-sharing data elements	KP	Create the ability to represent Indemnity and HMO plans correctly in the template. For example, indemnity plans do not have in-network or out-of-network benefits and HMOs have in-network only. Currently, have to add values just to get the template to validate.	Considering
Cost-sharing data elements	KP	For multi-tier benefits, allowing issuers to identify which benefits are in more than one tier would communicate benefits more clearly to consumers. The template currently allows cost sharing for more than one tier for those benefits, but does not support entering multiple tiers for all other benefits.	Considering
Cost-sharing data elements	KP	Regarding cost share variance, add the ability to have combination cost share options—for example, dollar coverage (at a copay/coinsurance/no charge/not covered) up to a certain dollar amount, then the option of copay/coinsurance/no charge/not covered. The template currently does not have this capability.	Deny
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: "Inpatient Hospital Services (e.g., Hospital Stay)", "Delivery and All Inpatient Services for Maternity Care", "Mental/ Behavioral Health and Substance Abuse Disorder Inpatient Services", "Skilled Nursing Facility", make the terminology in the drop down list box for these field be consistent since they are all provided on an inpatient basis; specifically, the cost sharing options for "per day" and "per stay" should appear for each of these fields; additionally, the drop down list box options for these fields should not be limited to "per day" and "per stay" (e.g., they should include all the other standard choices in the drop down list box).	Considering

Cost-sharing data elements	KP	“Inpatient hospital per day after deductible” didn’t reflect correctly on the CSV tab, and this caused confusion on the Connector in the State of Hawaii, which didn’t pull information from both tabs.	Considering
Cost-sharing data elements	KP	The drop-down box for cost sharing should allow an issuer to indicate “Not applicable” or “Not covered.” o “Not applicable” will allow issuers to list a copay as such if it is a coinsurance benefit and vice versa. “No charge” and “$0/0%” are very confusing. o “Not covered” will allow issuers to indicate that a benefit is not covered instead of populating 100% coinsurance and “No charge” for copay (e.g., for benefits that are not covered out-of-network).	Considering
Cost-sharing data elements	KP	Regarding cost share variance, add the ability to have “copay per day after deductible,” which is especially important for the Hospital Inpatient benefit. The template currently does not have this capability.	Considering
Cost-sharing data elements	KP	The templates are not set up for individual deductibles. For carriers that may not establish a family deductible, members are directed to the benefit summary rather than seeing the deductible on the web site, causing potential confusion for consumers regarding the plan benefits.	Considering
Cost-sharing data elements/AV	KP	The embedded AV calculator should determine the exact same AV as the stand-alone version. It does not always calculate the same value today (e.g., usually very close, but not exactly the same).	Accept

Cost-sharing data elements	AHIP	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.	Considering
Cost-sharing data elements	BCBSA	Multiple In Network Tiers data is collected at the Plan level, not the benefit level. However, the drop down menus for cost-sharing includes “No In-Network Tier Two” which may be an attempt to solve the issue. The Plan Compare display will be misleading unless selecting that value means the Tier Two value will not display. Suppress fields with the “No In- Network Tier Two” value	Accept
Cost-sharing data elements	KP	Address an inconsistency in the Plan and Benefit template for how inpatient coverage is handled by type of benefit. For example, there were options for copayment per day for inpatient hospitalization which were not available for maternity or chemical dependency/mental health. Suggest CMS amend this	Considering

Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: HSA/HRA Detail-- "HSA Eligible", "HSA/HRA Employer Contribution", "HSA/HRA Employer Contribution Amount", add a field to capture the application of the deductible for a family plan (i.e., is the deductible applied on a "per family" or “per person” basis) in order to have the ability to create logic to display correct deductible amount for individual vs family within the shopping experience.	Considering
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: Plan Cost Sharing Attributes -- "Explanation (text field)", clarify the intent of this field.	Accept
Cost-sharing data elements	AHIP	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	Deny
Cost-sharing data elements	AHIP	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.	Deny

Cost-sharing data elements	AHIP	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.	Deny
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: SBC Scenario, eliminate these fields since a consumer will have access to the actual SBC.	Deny
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: Each benefit entry -- "In Network Tier 1", "In Network (Tier 2)", "Out of Network", eliminate the choice of "No Charge" from the drop down list box for each cost sharing entry and adding "Not Applicable" as its replacement	Deny
Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab: "Primary Care Visit to Treat an Injury or Illness" & "Mental/ Behavioral Health and Substance Abuse Disorder Outpatient Services", add a field for these benefits that will capture the number of visits (on a combined basis) that an enrollee can have subject to the plan copay prior to the plan deductible being applied (e.g., to support Catastrophic plans).	Deny

Cost-sharing data elements	Access Health CT	Regarding Cost Share Variances Tab, there is a need for additional flexibility in this template to support certain non-standard benefits, some of which are mandated in Connecticut. Access Health CT would like to work with CMS and NAIC to ensure that the template can support these benefits. Examples of these are: --a separate deductible for Home Health Care, --Pediatric Eye Glasses that have an allowance depending on the type of frame selected, --combined out-of-pocket maximums for Out-of-Network coverage for medical and prescription drugs with a separate out-of-pocket maximum each for medical and prescription drug.	Deny
Cost-sharing data elements	BCBSA	Provide Plans with the flexibility to choose whether to provide either top-level, centralized URLs or Plan specific URLs for the plan brochure, Summary of Benefits and Coverage (SBC), provider directory, pharmacy, and payment redirect.	Deny
Cost-sharing data elements	United Concordia	“plan level exclusions” should be moved to the CSV tab, and there should be one exclusion cell for each benefit category. This would allow for plan comparisons at the benefit level and make it easier for consumers in the shopping process to identify plan exclusions and limitations	Deny
Cost-sharing data elements	KP	Add “Copay per day” as an option for some intended benefits such as Inpatient Mental Health or Substance Abuse.	Considering

Cost-sharing data elements	KP	In the Rx sections, add flexibility to display benefits beyond Copay/Coinsurance. Many benefits are a hybrid of the two.	Deny
Cost-sharing data elements	KP	Create ability to display a maximum dollar amount for Rx (i.e., 50% coinsurance up to a maximum of $500.)	Accept
Cost-sharing data elements	KP	In the future Plan and Benefit template, suggest removing the mandatory verbiage requirement of “Copayments, Premiums, and Balanced Billing” in the “Excluded Annual Out of Pocket Limit.”	Deny

Cost-sharing data elements	KP	Suggest including more flexibility with URLs.	Partially Accept
Cost-sharing data elements	NADP	The Cost Sharing Variance tab should describe in more detail the variances among policies for consumers. Carriers are unable to distinguish the variations amid cost sharing factors, such as deductibles and out-of-pocket limits in all policies except pediatric EHB products.	Deny
Cost-sharing data elements/AV	KP	It would be helpful in both the AV calculator and Plan and Benefit template to be able to enter a copay amount for Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services instead of just a coinsurance.	Deny

SBC	KP	With the SBCs, there was one overall link for each plan level, but it didn't get to the details of the CSR plans and the benefit differences and how the SBCs would be different from those.	Considering
Benefits	AHIP	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.	Considering
Benefits	AHIP	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.	Accept

Benefits	AHIP	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.	Considering
Benefits	AHIP, Access Health CT	We recommend the following specific changes for benefits listed in this template: “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.	Accept
Benefits	Access Health CT	Regarding Benefits Package Tab: Benefit Information (Benefits Listing), can we adjust the Connecticut specific benefits listing to eliminate items that are not EHB's and to adjust limits where necessary in advance of release of the templates for 2015.	Deny
Benefits	Access Health CT	Regarding Benefits Package Tab: Out of Network Coverage, confirm that response of "No" for this field will result in the Out-of-Network Cost sharing fields on the Cost Share Variance tab being greyed out.	Considering

Benefits	AHIP, KP	Provide a more detailed explanation (to include place of service) of listed benefits to reduce confusion	Deny
Benefits	AHIP	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.	Deny
Benefits	AHIP	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.	Deny
Benefits	AHIP	We recommend the following specific changes for benefits listed in this template: ▯ “Prenatal and Postnatal Care” should be listed as separate benefits.	Deny
Benefits	Access Health CT	Regarding Benefits Package Tab: Benefit Information -- "Limit Unit", "Other" should be included as an option in this drop down list box, with the ability for the user to identify what the customized limit is.	Deny

Benefits	Access Health CT	Regarding Benefits Package Tab: "Generic Drugs", "Preferred Brand Drugs", "Non-Preferred Brand Drugs", "Specialty Drugs", change the Prescription Drug Tier names to be more general in nature (e.g., 'Tier 1', 'Tier 2', 'Tier 3', 'Tier 4') in order to provide more flexibility in the drug composition for each tier and to reduce member confusion on what types of drugs are included in the various tiers.	Deny
Benefits	NADP	Include in the default configuration both Pediatric EHB, Pediatric non-EHB (like traditional Orthodontia), and Adult benefits in the Benefits Column. It would be more accurate to leave fields blank that don't apply than to have different jurisdictions – allowing the addition of benefits as carriers see necessary.	Deny
Benefits	NADP	Allow for additional background information within the dental categories is necessary. Carriers need to be able to explain the differences between “Basic” and “Major” by services. In addition, the benefit terms utilized within the child and adult categories are neither standard nor defined.	Deny
AV	AHIP	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.	Deny

AV	AHIP	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.	Deny
AV	AHIP	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.	Accept
AV	AHIP	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.	Considering
AV	AHIP	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.	Considering
AV	BCBSA	Modify the AV calculator so that results can be saved and submitted separately from the Plan and Benefits template. This would allow CMS to streamline the Plan and Benefits template to only include the fields that are required for Plan Compare.	Deny

Formulary	AHIP, KP	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.	Considering
Formulary	AHIP	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.	Considering
Formulary	AHIP	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.	Considering
Formulary	AHIP, KP	We recommend that CMS review the RxCUI list for gaps.	Accept
Formulary	AHIP	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.	Considering

Formulary	AHIP, BCBSA	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.	Considering
Formulary	Access Health CT	Regarding Drug Lists tab: Medical Drug Covered Under Medical Benefit/ Preventive Drug Covered at $0 Cost, use two different fields to identify whether a particular RxCUI is included under the medical plan or if it is subject to $0 copay under the Prescription Drug benefit since these items are distinct data elements.	Considering
Formulary	BCBSA	Provide clarity on how Plans can make changes to the template and provide a crosswalk of drugs	Considering
Formulary	KP	Improve the drug list count tool. We suggest working with Pharmaceutical Care Management Association to improve the functionality of that tool	Considering
Formulary	AHIP	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.	Deny

Formulary	AHIP	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.	Deny
Formulary	AHIP	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.	Deny
Formulary	AHIP	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.	Deny
Formulary	AHIP	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.	Deny
Formulary	AHIP	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	Deny

Formulary	AHIP	We recommend that the pharmacy benefit page be allowed to reflect coinsurance plan designs with the template.	Deny
Formulary	AHIP	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.	Deny
Formulary	AHIP	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	Deny
Formulary	Access Health CT	Regarding Formulary Tiers tab, add a field called "Tier Name" with Issuer completing the tier name used in marketing materials via free format text; this would give the Marketplace the ability to utilize this field to display naming convention for these benefits that is consistent with what Issuer uses.	Deny
Formulary	BCBSA	Provide Plans with a method for identifying tiers of drugs beyond all brand name or only generic. Furthermore, BCBSA recommends against using the term “all” and instead using the term “only,”	Deny
Formulary	KP	The use of the term “formulary” is confusing. CMS is asking issuers to provide information on cost sharing for prescription drugs, which would be better captured in the Plan and Benefit template.	Deny
Formulary	KP	Streamline the Prescription Drug template to only capture the drug list, which can then be tied to each plan ID in the Plan and Benefit template	Deny

Formulary	AHIP	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.	Deny
Issuer Business Rules	AHIP. KP+B299	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.	Considering
Issuer Business Rules	United Concordia	Allow template to accommodate rating for more than three dependents aged 0 to 20 years in SADPs. Currently, the template only has a category for “3 and above.” It would be more appropriate to restrict the rating for up to 3 pediatric dependents (ages 0 to 18) and allow SADPs to also rate for those non-pediatric dependents aged 19 and 20 who choose to remain covered by a non-EHB compliant SADP	Deny
Issuer Business Rules	United Concordia, NADP	The template should account for different definitions of “spouse” as some states permit domestic partners or civil union partners to be included within the definition of spouse while others do not (e.g. Virginia). The template currently uses the term “life partner” but that is ambiguous unless defined	Deny

Issuer Business Rules	KP	More explicit and clear dependent relationships need to be added for the question, “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as primary subscriber?” There was too much guesswork around this question for the 2014 submission, including lack of court-appointed dependent as an option and the use of “ward” to indicate “over-aged disabled dependents.”	Deny
Issuer Business Rules	NADP	For columns D, E & G, the dropdown options include '1', '2', and '3 or more'. This list should be more comprehensive and allow carriers the ability to select among ‘1’, ‘2’, '3', and '4 or more'.	Deny
Issuer Business Rules	BCBSA	Create distinct relationship codes to address the issues that arose last year and to reduce the potential for confusion derived from using codes to mean various things	Deny
Rating Table/Issuer Business Rules	United Concordia	Update the Rate Template for SADPs to show the pediatric rate age band as 0 to 18 years and allow the Business Rules Template to accommodate rating for more than three dependents	Deny
Rating Table	BCBSA	Adjust the template to untie the secondary subscriber and dependent rates from the subscriber age and allow for rates to be tied to each individual’s age	Deny
Rating Table	United Concordia, NADP	Allow issuers to enter rates for ages 0 to 18 years, not ages 0 to 20. Currently, for SADPs guaranteeing their rates, those aged 19 and 20 will be charged the same rate as those aged 0 to 18 but will receive a different, often much leaner, benefit.	Deny

Dental	AHIP, BCBSA, Access Health CT, KP	Create specific SADP templates instead of using modified QHP templates	Deny
Dental	AHIP, United Concordia, KP	Align SADP submission timelines with QHP submission timelines	Considering
Dental	AHIP, United Concordia	We recommend revising the dental benefit categories to clarify which benefits should be assigned to which categories (i.e., preventive diagnostic, major, and minor).	Accept
Dental	AHIP	Issuers should also have the flexibility to add benefits to the template (e.g., Minor Dental Service) to display on Plan Compare.	Accept
Dental	AHIP	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.	Considering

Dental	AHIP	Templates should include fields to provide plan details (e.g., waiting periods) for display in Plan Compare.	Accept
Dental	AHIP	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.	Accept
Dental	United Concordia	Modify the Plan and Benefits Template to include more detail to allow SADPs to differentiate plan details, including deductibles, out-of-pocket (OOP) maximums and annual maximums for adults, non-pediatric dependents and pediatric dependents	Accept
Dental	United Concordia	Provide clearer instructions on what is applicable and required for SADPs in the QHP certification process;	Accept
Dental	United Concordia	Template needs significantly more detail, including data regarding the dental benefits for adults, to accurately represent the plans in the Federally- Facilitated Marketplace (FFM). Currently, there is no way to differentiate the deductible, OOP maximum, or annual maximum for adults and non-pediatric children and those for pediatric children. The only data SADPs could submit and display was for pediatric children. For instance, the adults in a family plan would see that the SADP had a $700/$1400 OOP maximum; however, that only applied to the pediatric children on the plan. This is misleading	Accept

Dental	United Concordia	The current SADP benefit categories do not adequately represent dental plans in a meaningful way as the categories are too broad and are not consistent between adults and pediatric children. The categories should be broken down into types of dental services (e.g., periodontics, endodontics, diagnostic imaging, cleanings, etc.).	Accept
Dental	United Concordia	If the categories are broken down by dental services, this will allow issuers to assign a coinsurance level or copayment amount for each service. This will more accurately reflect various cost sharing designs and ensure consumers have a clear understanding of their out-of-pocket costs.	Accept
Dental	KP	If CMS continues to allow estimated dental rates, we suggest coordinating the processing of those rates with the Center for Consumer Information and Insurance Oversight (CCIIO) enrollment team. There still is not a way to process estimated dental rates.	Considering
Dental	AHIP, KP	Dental business rules template needs to accommodate rating more than three dependents; currently the template only has a category for "3 and above."	DENY
~~Dental~~	~~KP~~	~~Dental business rules need to accommodate rating more than three dependents. Currently, the template only has a category of "3 and above."~~	~~DENY~~

Dental	NADP	Add “Qualified Dental Plans” or “Stand-Alone Dental Plans” to parallel the listing of QHPs where appropriate.	Considering
ECP	AHIP, KP	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.	Accept
ECP	AHIP, BCBSA	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).	Accept
ECP	AHIP	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.	Accept

ECP	Access Health CT	Confirm that a State Based Marketplace has the flexibility to not require this version of an ECP listing, and that the Plan Management system within SERFF will not be impacted if it is omitted.	Accept
ECP	AHIP	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.	Deny
ECP	AHIP, BCBSA	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.	Deny

ECP	BCBSA	Provide NPIs and TINs in the list of ECPs and whether ECPs are able to contract with Plans	Deny
ECP	AHIP	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.	Deny
Network adequacy/Dental	AHIP	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.	Accept

Network adequacy	Access Health CT	Regarding Network Name, Network ID, Network URL, Dental Network URL, confirm that a Plan Type of "Indemnity" as entered in the Plans Benefits Template (for either medical or dental coverage) will not result in these fields being required in this template.	Accept.
Network adequacy	BCBSA	Clarify the specific format of the URLs that are required. Last year, CMS did not provide the specific format of the URLs. Some Plans entered only the core of the URL, without providing “http://” or “https://.” This led to nonfunctioning links being displayed on healthcare.gov. to be entered in the template	Accept
Network adequacy	BCBSA	CMS should defer to states on network adequacy and Plans for providing information to consumers on provider networks.	Deny
Provider Directories	Access Health CT	What data elements are to be collected in this new template in addition to those outlined in the Supporting Statement (i.e., provider name, county, and type); Understanding the anticipated use for the data would be helpful in determining whether additional fields are necessary.	Accept

Provider Directories	AHIP	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	Deny

Administrative Data Elements	AHIP, BCBSA	Clarify which plan marketing name will be displayed to consumers, the one collected in HIOS or the one collected in the Administrative Template	Accept
Administrative Data Elements	AHIP	CMS should 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	Accept
Administrative Data Elements	Access Health CT	Regarding 14. Third Party Administrator(s):Enrollment*Claims Processing*Edge Server Host*, include a drop down list box with "Yes / No" choices in order to know definitively whether the Issuer has a vendor for these services, with system logic added to display "Not Applicable" when a vendor is not used; this would eliminate any doubt as to whether an item was simply not completed erroneously.	Accept
Administrative Data Elements	BCBSA	Clarify how Plans may update information in the template after initial submission.	Accept
Administrative Data Elements	United Concordia	Provide information regarding the exact source of data for information to the FFM. Issuer data provided to shoppers on the FFM is from both the Plan Finder module and the Administrative Template	Accept

Administrative Data Elements	KP, AHIP, BCBSA	Provide definitions and uses for all contact names so plans can assign the appropriate parties.	Accept
Administrative Data Elements	KP	Use contact names that plans provide. Plans received phone calls and emails to individuals at their company who were not identified in the administrative template.	Accept
Administrative Data Elem	United Concordia	Use the customer service telephone number from the Administrative Template and not the Issuer Template to allow for more frequent updates	Deny
Administrative Data Elements	KP	Use the Individual Segment main contact as the single point of contact so that person can triage within the company as required. Plans have requested emails not go to the Chief Executive Officer (CEO) directly; it would have been more efficient to go directly to the Individual Segment contact.	Deny
Administrative Data Elements	KP, AHIP	Allow for more flexibility in the type and number of phone contacts that can be provided	Deny

Attestations	AHIP	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	Accept
Attestations	Access Health CT	Regarding Attestations, confirm that the attestations included in this document are not required for Issuers participating in State Based Marketplaces, as certain programs (e.g., Reinsurance) may differ from that of the Federal model.	Accept
Attestations	Access Health CT	Regarding Attestations, confirm whether the attestations included in this document are a replacement of or an addendum to those used for 2014.	Accept
Attestations	KP	These templates were difficult to use. It was hard to enter data and save the form, which caused issuers to have to print and scan into a PDF in order to upload into HIOS. It would be helpful if the form could be fillable PDF.	Accept
Accreditation/Timeline	AHIP	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.	Deny

CCIIO Response	Source Document Location
This is outside the scope of PRA.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 14, QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
Additional cost sharing options are being proposed to the template, including "Not Covered" and "Not Applicable." Note that the existing template already does allow for "Not Applicable" for deductible and out of pocket maximum fields.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 14
The "URL for Summary of Benefits and Coverage" data element is being proposed to move from the Benefits Package tab to the Cost Share Variances tab to allow for this.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 15, QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4

An additional drop down option for In Network (Tier 2) is being proposed to allow issuers to indicate that there is no multi in-network tier of providers for specitif benefit(s).	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17
HHS will include this information in the template instructions.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
Yes, the intent of proposing to move these fields is to allow greater flexibility in defining these data elements for all plan variation types	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
Additional cost sharing options are being proposed to the template, including "Not Covered" and "Not Applicable."	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 9
Additional cost sharing options are being propose to the template, including "Not Covered" and "Not Applicable." Issuers can use these options to indicate that a benefit does not have tiered cost sharing.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 11, QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17

Tying drop downs and subject to deductible as entered in the Benefits Package and Cost Share variances tab is template functionality and outside scope of PRA. Adding copay options of "before deductible" and "after deductible" will be proposed enhancements in the template for inpatient and skilled nursing facility.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 16
Zero cost sharing plan variation change has been proposed for the upcoming year. Denying requested HSA change because of complexity and level of effort needed to incorporate this type of funcationality into the template.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 11
This is the purpose of the question on the benefits package tab, "Out of Network Coverage"	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 12, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8
The HSA/HRA fields are being moved to the Cost Share Variances tab to allow issuers to enter information at the plan variation level.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4
HHS will provide guidance on how the data in the Plans & Benefits template is mapped to the standalone AVC.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 6

A new Out of Network coverage field is being added to the Benefit Package tab. If an issuer indicates that they do not offer out of network coverage, the out of network copay and coinsurance fields on the Cost Share Variance tab will be auto-populated with the value "Not Covered."	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 7
Additional cost sharing options are being added to the template, including "No In Network Tier Two" for plans that indicate that they have multi in network benefits. Issuers can use this options to indicate that a benefit does not have tiered cost sharing.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 7
This more nuanced cost sharing structure may be explained in the Explanation field and/or plan brochure.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 9
Proposing to add "per day" and "per stay" options to other inpatient benefits.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 5

Proposing to add the "before deductible" and "after deductible" qualifiers for this benefit.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8
These are proposed improvements to the templates.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8/10, QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 15
Proposing to add this data entry option.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 9
Proposed template improvements would collect whether the deductible and out of pocket maximum for families are per person and/or per family.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8
HHS will provide guidance on how the data in the Plans & Benefits template is mapped to the standalone AVC. (this is a issuer/user-error issue, not a template or AVC functionality problem). Also, in the stand-alone AV calculator in the User Guide, we have included additional guidance on how to input plan designs .	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 9

Proposed template improvement attempts to address this comment by including whether there is a per person deductible or out of pocket maximum on a per person basis for families enrolled in a given plan.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 16
Yes, this is the intent of our proposal to not display tier 2 cost sharing when "No In Network Tier Two" is selected.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 10
Proposing to add "per day" and "per stay" options to other inpatient benefits.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 7

Proposed improvement to tempate allow issuer to indicate if deductible and/or out of pocket maximum are per person and/or per family.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
This data element is redundant from what what is already on the template "Benefit Package" tab. We are removing this from the template.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
This more nuanced cost sharing structure may be explained in the Explanation field and/or plan brochure.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 16
This would increase the burden on many issuers by imposing a one size fits all data collection approach on them.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 16

This would increase the burden on many issuers by imposing a one size fits all data collection approach on them. Additional information can be included in the explanations field and/or plan brochure.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 16
This information is used on Plan Compre to inform consumer shopping.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 4
It has been proposed to add "Not Covered" to the dropdown, however the "No Charge" option will still exist as it has a different meaning.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 5
This would increase the burden on many issuers by imposing a one size fits all data collection approach on them. Additional information can be included in the explanations field and/or plan brochure.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 5

This would increase the burden on many issuers by imposing a one size fits all data collection approach on them. Additional information can be included in the explanations field and/or plan brochure.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 6
This would increase the burden on many issuers by imposing a one size fits all data collection approach on them.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 10
While we understand that this option would issuers the ability to more discretely label their plans, it would also increase the burden on many issuers by imposing a one size fits all data collection approach on them. It is also unclear why the issuer should be able to modify exclusions for plan variations.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 3
Proposing to add "per day" and "per stay" options to other inpatient benefits.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4

The AV Calculator requires that the benefit design be either copay or coinsurance and not a hybrid.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8
A "Maximum Coinsurance for Specialty Drugs" field is currently available. Additional detail can be provided in the explanations field and/or plan brochure.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8
While we understand that addressing this concern would issuers the ability to more discretely label their plans, it would also increase the burden on many issuers by imposing a one size fits all data collection approach on them.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 10

While we understand that addressing this concern would issuers the ability to more discretely label their plans, it would also increase the burden on many issuers by imposing a one size fits all data collection approach on them. In addition, we have made many changes to attempt to address this concern	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 10
While we understand that addressing this concern would issuers the ability to more discretely label their plans, it would also increase the burden on many issuers by imposing a one size fits all data collection approach on them. Additional detail can be provided in the explanations field and/or plan brochure.	QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3
The national claims database used to create the AVC's continuance tables does not include data on outpatient professional and facilities services at the stay level. Because copays are applied per stay, the AVC cannot support the option to enter a copay for these services. Users may convert their copays into coinsurance amounts to input their plan design into the Calculator. The Outpatient benefit categories in the Plans & Benefits template will have additional coinsurance fields specifically for the AVC. These fields will allow issuers to convert their copays into estimated coinsurance values for the AVC, while still entering the true copays for possible consumer display.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 8

The SBC URLs are being moved to the Cost Share Variance tab to allow issuers to enter the URLs at the plan variation level.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 7/8
A new Out of Network coverage field that has this functionality has been added.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 12
This is outside the scope of PRA. HHS will incorporate that guidance into the instructions. In addition, drop-down options are being modified for clarity.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 12

Weight loss programs shall be included as a data value for “Disease Management Programs Offered” in the benefit package tab of the Plans and Benefits template.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 13
Mental/Behavioral Health and Substance Abuse Disorder have now been re-separated to ensure that information is accurately/discretely collected from issuers.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 13
States were given the opportunity to confirm EHB and State Mandated Benefits and how they would be displayed via the add-in file. Issuers have the ability of changing the auto-populated limits provided an EHB Variance Reason is included, which is specified in the instructions.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 2
Yes, this is the proposed intent for non emergency benefits allowing the issuer to indicate that out of network services are not covered (e.g., typical HMO design).	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 2

Issuers are given the opportunity to describe their interpretation of the benefit in the Benefit Explanation column and/or plan brochure	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 13, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 7
Issuers are given the opportunity to describe their interpretation of the benefit in the Benefit Explanation column and/or plan brochure	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 11
Issuers can provide more detailed information in the explanations field and/or plan brochure. Additionally, this change may complicate the story for consumers seeking information on Plan Compare (HC.gov).	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 12
Altering the prenatal and postnatal categories would alter the benchmark because "Prenatal and postnatal care" is how the data were collected for the September 2012 benchmark data collection.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 13
Limits with Limit Units not included in the drop down list can include the limit in the Benefit Explanation free text field.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 3

The four pre-defined drug benefit categories in the Plans & Benefits template correspond with the drug benefits in the AVC. HHS will continue to work with the issuer community to modify the drug data collection so that it more closely aligns with industry practices.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 3
When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the Plan and Benefits template.	QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3
When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the Plan and Benefits template.	QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3
The purpose of AV is to determine the issuer's cost sharing generosity and therefore, the calculator was developed to reflect issuers' coinsurance rate.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 11

AV Calculator returns a value as a percentage. The Plans and Benefits template is consistent with this data type.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 14
HHS will provide guidance on how the data in the Plans & Benefits template is mapped to the standalone AVC. Also, in the stand-alone AV calculator in the User Guide, we have included additional guidance on how to input plan designs .	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 14
This is not within PRA scope; however, CMS will improve its instructions to issuers for the upcoming year to minimize confusion and the need for subsequent fixes.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 15
We will consider aligning these decimal places. Both templates can still be completed accurately and submitted to pass validations if this change is not made.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 15
In order to ensure consistency between the cost sharing values used for the AVC and the cost sharing displayed on Plan Compare, HHS will continue to collect AV information via the Plans & Benefits template.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 12

Propose adding this field to the 2015 Prescription Drug template to allow issuers to identify those drugs covered under medical service benefit as well as those drugs that would be covered under zero cost share preventives benefit.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
The proposed 2015 template will allow for entry of 2 digits after the decimal point.In order to assist issuerswith presenting the most accurate cost shares that will be charged to consumers.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
This is outside the scope of the PRA.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
CMS will strive to continuously improve the EHB-Rx Crosswalk.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 19, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
This is outside the scope of the PRA.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 19

This is outside the scope of the PRA.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 19, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 13
Propose adding this field to the 2015 Prescription Drug template to allow issuers to identify those drugs covered under medical service benefit as well as those drugs that would be covered under zero cost share preventives benefit.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 2
This is outside the scope of the PRA.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 13
CMS will strive to continuously improve the EHB-Rx Crosswalk.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
The prescription drug cost share must be included in the Plans and Benfit template in order to link template information together, allow for these cost shares to be displayed on Plan Compare (as Plan Compare site pulls data from the Plans and Benefit template only), as well as for AVC cost share accessibility.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17

The prescription drug cost share must be included in the Plans and Benfit template in order to link template information together, allow for these cost shares to be displayed on Plan Compare (as Plan Compare site pulls data from the Plans and Benefit template only), as well as for AVC cost share accessibility.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17
CMS will continue to analyze requested data elements to ensure that only necessary data elements are requested from issuers.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17
The prescription drug cost share must be included in the Plans and Benfit template in order to link template information together, allow for these cost shares to be displayed on Plan Compare (as Plan Compare site pulls data from the Plans and Benefit template only), as well as for AVC cost share accessibility.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 17
Additional information can be provided in the explanations field and/or plan brochure.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
Issuers should enter "NA" in the Tier Level field to indicate that particular drugs that are not covered. If plans have varying drug coverage, the issuer should create multiple drug lists to represent the coverage for each plan accurately.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18

HHS is considering modifications to the templates for future years.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
Additional detail can be provided in the explanations field and/or link to the formulary	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
HHS is considering modifications to the templates for future years.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 18
Functionality already in place to reflect that a drug is not covered on the drug list as Issuers should enter "NA" in the Tier Level field to indicate that a particular drug is not covered. If plans have varying drug coverage, the issuer should create multiple drug lists to represent the coverage for each plan accurately.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1
HHS is considering modifications to the templates for future years.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 12
The prescription drug cost share must be included in the Plans and Benfit template in order to link template information together, allow for these cost shares to be displayed on Plan Compare (as Plan Compare site pulls data from the Plans and Benefit template only), as well as enable AVC cost share accessibility.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4
HHS is considering modifications to the templates for future years.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4

The prescription drug cost share must be included in the Plans and Benfit template in order to link template information together, allow for these cost shares to be displayed on Plan Compare (as Plan Compare site pulls data from the Plans and Benefit template only), as well as allow for AVC cost share accessibility.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 14
The proposed templates are being adusted to conform with the final Market Rules.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 20, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
CCIIO is researching the feasibility of creating a dental-specific Business Rules template for future years.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 2
CCIIO is researching the feasibility of adding or modifying relationship codes to allow for multiple definitions of spouse for future years.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 3, QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 2

CCIIO is researching the feasibility of adding or modifying relationship codes to allow for more flexibility regarding the reporting of primary-dependent relationships for future years.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
For medical issuers, a dropdown option of four or more is invalid. For dental issuers, HHS is considering modifications to the templates for future years.	QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3
CCIIO is researching the feasibility of adding or modifying relationship codes to allow for more flexibility regarding the reporting of primary-dependent relationships.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 14
HHS is considering modifications to the templates for future years.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 1
This is outside the scope of PRA.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 14
HHS is considering modifications to the templates for future years.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 2, QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3

HHS is considering modifications to the templates for future years.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 21, QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 4/10/14, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
This is outside the scope of PRA.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 21, QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 1/4, QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 6
Issuers should identify benefits based on each state-specific benchmark plan.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 21, QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 1
Issuers may use the Add Benefit button on the menu bar under the Plans and Benefits ribbon to add a benefit that is not in the template.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 22
HHS appreciated your feedback and is currently working to accommodate the age bands 0-18 and 19-20. Additional guidance will be provided in the near future if this change is implemented and on the definition of pediatric age bands.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 22

Plan details can be entered in the Exclusions and Benefit Explanation field, which are free text fields.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 22
CMS proposes to collect the average premium actually charged compared to the estimated rates to determine the average difference, using the 2015 Plan and Benefits Template . This data is being collected for informational puposes only. Further guidance on this collection will be available soon.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 22
When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the plan and benefits template.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg.1
This is outside the scope of PRA. HHS will be sure to include what is applicable and required for SADPs in the template instructions.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 1
When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the plan and benefits template.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 2

When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the plan and benefits template.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 2
When filling out the template, a plan may add additional or more granular benefits and limits using the "add benefit" button in the plan and benefits template.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 2
CMS proposes to collect the average premium actually charged compared to the estimated rates to determine the average difference, using the 2015 Plan and Benefits Template. This data is being collected for informational puposes only. Further guidance on this collection will be available soon.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
Thank you for your feedback. We will take this into consideration when revising the template for subsequent plan years.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 22 QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
~~Thank you for your feedback. We will take this into consideration when revising the template for subsequent plan years.~~	

This is outside the scope of PRA. We will continue to refer to dental plans as "stand-alone dental plans" or SADPs. This is consisent in the verbage used previously for the 2014 coverage year and will be used again for 2015. If possible, we will try to add QDP where appropriate.	QHPNADP_Comments_on_Plan_Templates_12_31_13_Final.pdf pg. 3
HHS will provide further guidance in the instructions. HHS will work to provide information on ECP standards for the 2015 benefit year to issuers as soon as feasible.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8
HHS will work to ensure that provider information is up to date.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 8
HHS will provide further guidance in the instructions to allow providers with multiple locations to list each location, despite having the same NPI.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 9

2014 to ensure that QHP issuers have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. Such flexibility would include CCIIO not requiring issuers in SBEs to use a specific version of the ECP listing, although the state may mandate such a requirement.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1
For the 2015 benefit year, HHS intends to revise the ECP template to allow issuers to indicate whether they are a Standard Issuer or Alternate Standard Issuer. Standard Issuers will not need to identify provider type; rather, they will only need to indicate ECP category. However, Alternate Standard Issuers will need to indicate provider type, but not ECP category. Therefore, HHS will not entirely remove provider type from the template because it is applicable to Alternate Standard Issuers.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8
For Indian providers and/or providers on CMS' non-exhaustive list of Essential Community Providers, issuers must contract with the corporate entity named on the CMS list for that provider to be counted as an ECP. Individual practitioners having the same address as another ECP on the CMS list will not be counted as ECPs for purposes of meeting this standard. For "write-in" ECPs that are not on the list, but still provide care to medically underserved and vulnerable populations, CMS will credit the issuer with only one ECP per street address. HHS will provide further clarification in the template instructions.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 9, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 8

HHS's collection of NPIs is for the purpose of ensuring that no ECP (individual or group practice) at a single location is listed more than once on the CMS-generated list. However, some providers do not have NPIs and publication of NPIs/TINs is not considered essential for issuers to select ECPs among the list.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 8
For plan year 2014, we provided a non-exhaustive listing of ECPs, which included only 340B providers and 1927(c)(1)(D)(i)(iv) providers. This list included tribal organization providers and urban Indian organization providers, which are 340B eligible providers. We also released a separate listing of all Indian health providers, which included Indian Health Service facilities, along with tribal organization and urban Indian organization providers. We provided two lists, because Indian Health Service facilities are not 340B eligible providers and we wanted to identify the full range of Indian health providers for QHP issuers. For plan year 2015, we will continue to provide these lists separately to assist issuers with quickly identifying Indian providers, given the historic and unique government-to-government relationship with Indian tribes and because a significant portion of American Indians and Alaska Natives (AI/ANs) access care through longstanding relationships with providers in the Indian health system.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8
HHS will provide clarification in the template instructions	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 9

HHS will attempt to accomedate this in template design if operationally feasible	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1
HHS will include this information in the template instructions	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 9
HHS believes that network provider information is necessary for an adquate access review and is therefore collecting provider data.	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 5
Will update supporting statement to clarify use of the data and release a template mock-up for the next comment period. HHS will be explaining the data collectiong in the Annual Letter.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1

HHS believes that network provider information is necessary for an adquate access review and is therefore collecting provider data.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 9

HHS will include this information in the template instructions	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 7
HHS is working to minimize the amount of information that is duplicative on Plan Finder and in the Administrative template	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 7
HHS is investigating making this change if operationally feasible	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 1
HHS will continue to improve communication processes with issuers throughout the 2015 submission cycle	QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 8
HHS is working to minimize the amount of information that is duplicative on Plan Finder and in the Administrative template and will clarify data sources in the QHP Application instructions	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 3

HHS will include this information to the template instructions	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4, QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 7, QHPBCBSA_Comment_Letter_on_the_Initial_Plan_Data_Collection_-_12-31-13.pdf pg. 7
HHS is working to improve communication about the sources of contact information. Contacts provided to the HIOS system are also used for commuincations with Issuers	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4
Question is unclear, as no "Issuer Template" is included in the QHP PRA package. They might be referring to the Issuer Template that was part of original RBIS data collection. HHS intends to continue to collect customer service numbers through HIOS to allow for more frequent updates.	QHPHCR-QHP_Templates_for_2015_-_UCD_Comments_final_12-31-13.pdf pg. 1/3
HHS uses multiple points of contact for different purposes to minimize the risk of lost communications and target communications by topic to the right person. Plans should not provide contact information for individuals that they prefer HHS not contact	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 4
Need more specifics to adequately address this issue	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 10, QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 8

HHS is working to eliminate the Statement of Detailed Attestation Responses from the data collection.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 21
Issuers participating in State Based Marketplaces will have to complete a smaller set of attestations as applicable to State Based Marketplaces.	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 6
The attestations included in this document proposed as the complete list of attestations required for 2015 plan year certification, as a replacement to the set required for 2014	QHPAHCT_Comments_CMS-10433_QHP_Templates2015.pdf pg. 6
HHS is working to eliminate the Statement of Detailed Attestation Responses from the data collection.	QHPKaiser-Permanente_Comments_on_CMS-10433_12_31_13.pdf pg. 5
CCIIO currently validates the issuer submissions with information provided by the accrediting entities. If the issuer submitted information does not match the accrediting entity then the issuer has incorrect information and should work with the accrediting entities to make corrections. Data collected from the issuer is necessary to do this validation.	QHP_Application_PRA_AHIP_Comment_Letter_FINAL_12-20-13[1] pg. 9