# Appendix N. QHP Certification 60-Day Comment Summary Responses to Paperwork Reduction Act Notice Published August 3, 2015

## Initial Plan Data Collection to Support QHP Certification (CMS-10433)

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Application process | Recommends that CMS provide issuers with the opportunity to review (but not necessarily edit) the QHP Application in HIOS at any point | N/A | We will continue to consider the technical feasibility of allowing issuers to review the QHP Application in HIOS at any point but do not believe this will be feasible for 2017 plans. |
| Burden | Objects to several data points due to concern that burden is excessive. | N/A | CMS believes that burden estimates accurately reflect the time it takes for an issuer to complete the activities noted in this package and bases its estimates on experience from the certification process for 2014-2016. |
| Burden | Concern that CMS is creating unnecessary burden on issuers through the state certification form and that CMS should collect information directly from state insurance departments. | N/A | The reference to the state certification has been removed. A certification form is not required. |
| Burden | Objects to burden created based on data elements for off-Marketplaces plans for Risk Adjustment, Reinsurance, and Payment Operations. | N/A | With regards to Appendix D Plan Data Elements, these data elements are essential to the calculation of plan liability risk scores and risk adjustment transfers. These data elements are required of all Affordable Care Act-compliant, non-grandfathered individual and small group market plans, on and off the Exchange. These plans are considered risk adjustment covered plans under the Affordable Care Act's permanent risk adjustment program. We note that plan types such as grandfathered plans and Medicaid plans are not subject to the risk adjustment program and therefore, not subject to this data collection. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Recommends that CMS include issuer logos on the FFM. | N/A | We will continue to consider the technical feasibility of including issuer logos. |
| Data collected | Recommends that CMS have the data integrity tool provide more detailed error information and align the validation checks within the DIT tool and the HIOS portal. | N/A | This comment is out of scope to this PRA package, as the data integrity tool does not involve a collection of information and is therefore not part of this information collection. |
| Data collected | Suggests that CMS revisit the fields in the Administrative Data Template against what is also provided by issuers in the HIOS Marketplace Issuer Data Fields in HIOS Plan Finder to avoid duplication. | Administrative Data Template | CMS continues to work towards streamlining the QHP application process, including the administrative data collection. |
| Data collected | Suggests that CMS allow for additional flexibility for issuers to set age requirements for grandchildren and dependents of minor dependents and categorization of domestic partners and other partnership situations. | Business Rules Template | We will consider the technical feasibility of allowing issuers to define additional business rules in future years. While we are not changing the allowed business rules for plan year 2017, we will seek issuer feedback as to which changes and additions would be most useful before making changes in the future. |
| Data collected | Supports creating a new field in the essential community provider (ECP) issuer application template to document the number of DMDs and DDSs authorized by the state to independently treat and prescribe within a facility. | Essential Community Provider Template | We are modifying this data field in the ECP template to collect the number of practitioners with whom the issuer has contracted among the available practitioners reported by the facility via the ECP petition and as reflected on the ECP list. |
| Data collected | Recommends that CMS allow issuers to write in ECP providers that are missing from CMS' list. | Essential Community Provider Template | This comment is out of scope to this PRA package, as the template does not include a write-in feature. Any changes to the current ECP policy itself would not be through the PRA process, which is limited to collections of information. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Recommends that CMS rely on data provided in the ECP Provider Petition to capture the number of contracted MDs, DOs, PAs, and NPs rather than adding a new field to the ECP Template. | Essential Community Provider Template | We are adding this new data field to the ECP template to capture the number of practitioners with whom an issuer has contracted, as opposed to the number of practitioners that the provider has indicated are available at its facility via the ECP petition. |
| Data collected | Recommends that 340B participation and HPSA fields also be reflected on the ECP List and that the ECP Review Tool is updated when the ECP List is updated. | Essential Community Provider Template | This comment is out of scope to this PRA package, which does not involve the ECP list. |
| | ECP Template and ECP Tool should have formulas updated to accommodate for multiple rows if name or National Provider Identifier (NPI) is the same for multiple locations of the same provider on the ECP list. Instructions should also be updated accordingly to provide issuers with clear guidance on how to address duplicate providers with multiple addresses but a single NPI. | Essential Community Provider Template | We plan to embed the HHS ECP List within the ECP template, so that issuers will electronically select ECPs from the ECP List and the provider data will auto-populate the issuer's template and eliminate the complexities associated with issuers manually entering providers with multiple addresses and a single NPI. |
| Data collected | Where CMS proposes adding new data elements, provide additional detail regarding how the data will be used for QHP certification and/or public display. | N/A | Network adequacy template – We are proposing adding a field to collect tiering information. We believe this information is necessary to help us better understand how the network is structured and how reasonable access is being provided.<br><br>ECP template – We are proposing to collect the number of contracted practitioners at each facility. We believe this information will allow CMS to have more complete data on the provider participation within an issuer's provider network.<br><br>Plans & Benefits template – New data fields to capture mental health, substance abuse, and specialist cost sharing are intended to ensure that the template can accommodate potential changes |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | | | to the AV Calculator in the future. Information about the plans' AV calculation is collected during QHP certification and is a requirement established at 45 CFR 156.135 and 156.140. These data may also be used by CMS to display more detailed cost sharing information to consumers in the future.<br><br>Plans & Benefits template – The new data field, "Plan design type" would allow issuers to indicate whether each plan has a particular cost sharing design. A number of State-based Marketplaces require issuers to offer uniform plan designs at various metal levels. Adding this data element will assist states in reviewing plans. |
| Data collected | Recommends that the Network URL be moved from the Network Template to the Plans & Benefits Template. | Network Template | This URL was put in this specific template for administrative reasons. We will take this recommendation into consideration for the future. |
| Data collected | Requests confirmation that a Plan Type of "Indemnity" entered into the Plans & Benefits Template will not result in those fields being required in the Network Template | Network Template | Indemnity plans are not required to fill out the network adequacy provider template. |
| Data collected | Does not support the addition of tier and cost-sharing information. Recommends that if CMS collects this information, CMS add a place for issuers to provide a description of their plan network and how enrollees can access benefits. | Network Adequacy Template | It important for CMS to understand how issuers structure plans and provide benefits in accordance with the requirement to provide reasonable access to all covered services. In order to understand this, we are requesting tier information as part of network provider data that we collect. Issuers provide additional information about benefit design in other areas of the QHP application. |
| Data collected | Recommends adding provider type listing for additional categories of behavioral health and substance abuse providers. | Network Adequacy Template | We believe this is adequately addressed under the category of mental health. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Recommends not creating a new data field to capture the Essential Health Benefit category for each service listed ("EHB Category"). | Plans and Benefits Template – Benefits Package tab | The data fields are necessary in order to evaluate mental health parity in accordance with regulations. |
| Data collected | Unclear on the distinction between new data fields to capture limitations for essential health benefits ("Visit Limits") and existing fields ("Quantitative Limit on Service" and "Quantity Limit Information") | Plans and Benefits Template – Benefits Package tab | Existing fields that address limits on services may allow for drop down options such as "Care Plan required on or after ## visits"/"Approval required on or after ## visits"/"Limited to ## visits per plan year," etc. |
| Data collected | Recommends that including benefit information for "Off-Exchange" only plans within the same template remains optional | Plans and Benefits Template – Benefits Package tab | For QHP certification by CMS, cost sharing information is required of the issuer for Off-Exchange, including Off-Exchange dental plans, in order to validate and finalize the information. |
| Data collected | Notes need for organizations to modify design systems to capture elements from a different template location if the "AV Calc. Additional Benefit Design" is moved | Plans and Benefits Template – Benefits Package tab | We update the AV Calculator annually and the AV Calculator for the given benefit year must be used. We also anticipate remapping the inputs between the AV Calculator and Plans and Benefits Template when these features are moved. |
| Data collected | Recommends that "Other, specify" be included in the drop down list for "Limit Unit" | Plans and Benefits Template – Benefits Package tab | While we appreciate the comment, this is not a change the template can accommodate at this time. |
| Data collected | Requests clarification for "Which benefits begin cost sharing after set of visits?" and "Which benefits begin deductible/coinsurance after set copays?" including whether these are free-form fields or drop down menus. Recommends rewording the question, "Which benefits | Plans and Benefits Template – Benefits Package tab | As these features would map to the AV Calculator, the options to select would align with the AV Calculator options and would only be available for a limited set of benefits thereby eliminating any potential for inconsistencies. These inputs would not be freeform, and we intend to provide clarification on this mapping in the QHP application instructions. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | begin deductible/coinsurance after set of copays?" to clarify and eliminate potentially inconsistent responses between this question and the question, ""Begin primary care cost-sharing after a set number of visits?" Recommends moving these fields to the Cost Share Variance Tab. | | |
| Data collected | Recommends that the Plan Marketing Name field be an editable field once populated when the cost share tab is created | Plans and Benefits Template – Benefits Package tab | We plan to make Plan Marketing Name editable on the Cost Sharing Variance tab for plan year 2017. |
| Data collected | Recommends that the new field indicating whether each plan has a particular cost sharing design be optional or allows issuers to indicate "not applicable" | Plans and Benefits Template – Benefits Package tab | The "Plan design type" field will either be optional or allow issuers to indicate that the field is "not applicable" for a particular plan. We intend to provide further instructions on the field will accompany the release of the 2017 Plans & Benefits Template. |
| Data collected | Recommends not including the field referring to Care Plan Limit. Requests more information on the "Care Plan Limit" column including how and when the field will be used, whether it is limited to specific benefits, drop down options, definitions, and instructions | Plans and Benefits Template – Benefits Package tab Care Plan Limit | Without Care Plan Limit, the Plans & Benefits Template cannot be used to auto-populate an effective MHPAEA outlier tool that addresses non-quantitative limitations. |
| Data collected | Recommends creating a separate entry for "Mental Health Office Visits" and "Substance Abuse Office Visits" in the Outpatient office visits sub-classifications and deleting "Mental/Behavioral Health Outpatient Services," "Substance Abuse Disorder Outpatient Services," and | Plans and Benefits Template – Benefits Package tab Mental health | We devised these categories based on categorization permitted under mental health parity regulations. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | "Mental Health Parity" | | |
| Data collected | Recommends removing all proposed data elements related to mental health parity reviews. Requests additional information regarding the proposed data fields to support mental health parity reviews, including clear definitions and examples and explanations of the overlap with existing mental health categories. | Plans and Benefits Template – Benefits Package tab Mental health | We appreciate the recommendation; however, we are including these elements so that states can use them as part of a future mental health parity tool to determine compliance. We intend to provide further instruction in the future. |
| Data collected | Recommends that the new data fields "Which benefits begin cost sharing after set number of visits" and "Which benefits begin deductible/coinsurance after set number of copays" apply to any combination of primary care, specialist, and mental health/substance use visits. | Plans and Benefits Template – Benefits Package tab Mental health | The fields will allow the issuer to specify any combination of primary care, specialist, and mental health/substance use limits. |
| Data collected | Recommends that the AV Calculator provide issuers the option to respond separately for mental health/substance use facilities and office visit categories | Plans and Benefits Template – Benefits Package tab Mental health | This comment is out of scope to this PRA package. CMS intends to provide a comment period to the draft AV Calculator at a separate time. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Recommends that CMS only collect cost share and limitation data for office visits, outpatient services, and emergency services for mental health, substance use, and behavioral health in one tab | Plans and Benefits Template – Benefits Package tab Mental health | Technical limitations related to the Plans & Benefits Template preclude capturing cost sharing variance information on the same worksheet. We continue to evaluate ways to streamline information collection. |
| Data collected | Suggests adding a Mental Health and Substance Abuse Outpatient Other category | Plans and Benefits Template – Benefits Package tab Mental health | Mental health parity regulations allow mental health and substance use disorder outpatient office visits to be divided between outpatient office visits and all other outpatient visits; those categories are currently in the template. |
| Data collected | Recommends not collecting "Plan design type" benefit field. Recommends making the field optional. Requests more information regarding the definition of the "plan design type" field in relation to "plan type." | Plans and Benefits Template – Benefits Package tab Plan Design Type | CMS believes it is important to collect this field. In particular, states that operate their own Marketplace may wish to use this field. The "Plan design type" field will either be optional or allow issuers to indicate that the field is "not applicable" for a particular plan. We intend for further instructions on the field to accompany the release of the 2017 Plans & Benefits Template. The current "plan type" field is a required field that allows issuers to define the product network type of a plan (HMO, POS, PPO, EPO, indemnity). The proposed "plan design type" field will allow issuers to indicate that a plan has a pre-defined cost sharing design. |
| Data collected | Requests that the new data field to capture cost share variant level information for the plan marketing name be optional and recommends ensuring that the number of characters in this field do not exceed the standard in place for EDI. Supports proposed change to capture cost share variant level information for plan marketing name and recommends | Plans and Benefits Template – Cost Share Variances tab | CMS intends to make the new data field for capturing cost share variant level information for the plan marketing name an optional field and also ensure that the number characters in this field do not exceed the standard in place for EDI. CMS also intends to auto-populate and allow edits based on the plan marketing name for the standard plan. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | continuing to auto-populate and allow edits based on the plan marketing name for the standard plan. | | |
| Data collected | Recommends adding the options of "per day" and "per stay" (with and without deductible) for other services that can be obtained while an inpatient is in the hospital | Plans and Benefits Template – Cost Share Variances tab | The implementation of this recommendation would compromise the current logic used to calculate cost-sharing and its relation to AVC. |
| Data collected | Suggests that CMS add fields so that minimum and maximum values for Employer's Contribution to HRAs/HSAs are captured | Plans and Benefits Template – Cost Share Variances tab | For the purposes of the AV calculation, the plan can only have one employer contribution amount as the employer contribution amount is being mapped to the AV Calculator and being taking into account for the AV calculation. |
| Data collected | Recommends updating the AV Calculator to allow for more flexibility in how co-pays can occur, including vision or dental visit co-pays. | Plans and Benefits Template – Cost Share Variances tab AV Calculator | This is out of scope to this PRA package. CMS intends to provide a comment period to the draft AV Calculator at a separate time. |
| Data collected | Recommends that the AV Calculator include Speech Therapy and Occupational and Physical Therapy categories | Plans and Benefits Template – Cost Share Variances tab AV Calculator | This is out of scope to this PRA package. CMS intends to provide a comment period to the draft AV Calculator at a separate time. |
| Data collected | Opposes moving the AV Calc. Additional Benefit Design to the Cost Sharing Variance tab | Plans and Benefits Template – Cost Share | The Plans & Benefits Template does not allow issuers to vary the "Additional Benefit Design" options between silver plan variants. Silver plans variances have different AVs and can vary cost sharing for the Additional Benefit Design features. The purpose |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | | Variances tab AV Calculator | of this change would be to allow users the flexibility to vary these features for silver plans in the template and could help ensure that some users can use the integrated version of the AV Calculator in the Plans & Benefits Template (instead of submitting their plans as unique plan designs). |
| Data collected | Suggests that the Plan & Benefits Template be consistent with any upcoming changes made to the AV Calculator | Plans and Benefits Template – Cost Share Variances tab AV Calculator | We will consider changes being made to the AV Calculator when considering updates to the Plans & Benefits Template and will continue to look ways to ensure more consistency between templates. |
| Data collected | Recommends eliminating additional new data fields to capture SBC scenario or making them optional for the first year. Recommends eliminating existing fields to capture the cost of having diabetes and having a baby. | Plans and Benefits Template – Cost Share Variances tab SBC Scenario | QHP issuers are required to provide the Summary of Benefits and Coverage (SBC) in a manner compliant with the standards set forth in in 45 C.F.R. 147.200, which implements section 2715 of the PHS Act, as added by the Affordable Care Act. Specifically, issuers must fully comply with the requirements of 45 C.F.R. 147.200(a)(3), which requires issuers to "provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance." |
| Data collected | Supports the requirement to provide fill quantity and fill limits, but not the addition of pharmacy restrictions and over-the-counter requirements | Prescription Drug Template – Formulary tab | Knowing if the dispensing of a drug is restricted to a particular pharmacy would be beneficial to consumers. Similar to the standard step therapy data currently collected, OTC step therapy requires the step therapy to include the use of over-the-counter equivalences first. Both limits are industry standards and currently being collected for Medicare Part D submissions. |
| Data collected | Requests that specific definitions of terms related to the proposed "Quantity Limits and "Fill Limits" fields be added | Prescription Drug Template – Formulary tab | Quantity limits and fill limits are recognized terms used in the pharmacy industry. Additional clarification language may be added in the template guidelines and instructions. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Requests clarification on what is considered a pharmacy restriction and information on how proposed changes for 1/1/2017 requiring access through physical pharmacies may affect the use of this field | Prescription Drug Template – Formulary tab | Knowing if the dispensing of a drug is restricted to a particular pharmacy would be beneficial to consumers. Currently, this data will not be collected in the 2017 RX template, although this may change. |
| Data collected | Supports moving the cost sharing information collected on the Formulary Tiers tab to the Plans & Benefits instrument, assuming that the issuer is able to select a cost share maximum in co-insurance plans that differs across the Silver variant plans | Prescription Drug Template – Formulary tab | We appreciate the recommendation; however technical limitations related to the Plans and Benefits template prevent the addition of cost share maximum data for coinsurances across variant plans at this time. |
| Data collected | Recommends also moving tiering and tier name descriptions and drug cost sharing information to the Plans & Benefits template. | Prescription Drug Template – Formulary tab | We appreciate the recommendation but we do not believe it is technologically feasible at this time. Additionally, we believe it is functional in the current location. |
| Data collected | Requests clarification of CMS' approach for inputting the number of tiers and associated cost sharing and recommends allowing issuers to input up to 7 tiers using the current approach | Prescription Drug Template – Formulary tab | We appreciate the recommendation of allowing issuers to input up to seven tiers in the Plans and Benefits template. We will consider the technical feasibility of this change for future years. |
| Data collected | 2 commenters recommend moving away from categorical approach to tiering and toward a numerical approach ("Tier 1," "Tier 2," "Tier 3," etc.) | Prescription Drug Template – Formulary tab | CMS continues to work towards streamlining the QHP application process, including the labeling of drug tiers. |
| Data collected | Recommends displaying specialty and non-specialty drug copayments for each tier, or displaying the non-specialty drug copayments for each tier | Prescription Drug Template – Formulary tab | Although the current PRA package does not include changes to display specialty and non-specialty drug copayments for each tier, we will consider these options for future years. |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| Data collected | Recommends that CMS organize the Plans & Benefits tab to use the same drug types that are used in the Prescription Drug Template, or that CMS uses the data in the Prescription Drug Template to populate healthcare.gov | Prescription Drug Template – Formulary tab | We will consider the technical feasibility of allowing the Plans and Benefits template to capture the drug type data that are used in the Prescription Drug Template and populating healthcare.gov with data from the Prescription Drug Template in future years. |
| Data collected | Recommends not adopting the proposed changes for capturing quantity limits, fill limits, and pharmacy restrictions for each RxCUI as well as OTC step therapy protocols | Prescription Drug Template – Formulary tab OTC | Fill limits and quantity limits data will be useful to consumers when choosing a plan. Knowing if the dispensing of a drug is restricted to a particular pharmacy would be beneficial to consumers. Similar to the standard step therapy data currently collected, OTC step therapy requirements extend the step therapy to over-the-counter equivalences of the drugs. Both limits are industry standards and currently being collected for Medicare Part D submissions. |
| Data collected | Requests clarification on whether the "Over-the-Counter Step Therapy Protocol" field would apply only to step therapy programs where all agents in the step protocol are over-the-counter | Prescription Drug Template – Formulary tab OTC | OTC Step Therapy only applies to drugs that require the use of an OTC drug first. The current Step Therapy data pertains to other prescription drugs. |
| Data collected | Requests confirmation of whether the parameters for the "Over-the-Counter Step Therapy Protocol" field will take into account that many QHPs use a P&T committee to approve the clinically appropriate use of a step therapy program | Prescription Drug Template – Formulary tab OTC | Issuers are required to adhere to the P&T Committee standards in determining the appropriate use of step therapy restrictions. Similar to the standard step therapy data currently collected, OTC step therapy requires that the step therapy include the use of over-the-counter equivalences first. This data is currently being collected for Medicare Part D application submissions. |
| Data collected | Requests clarification regarding how OTC Step Therapy is distinct from the existing step therapy data element | Prescription Drug Template – Formulary tab OTC | The OTC Step Therapy restriction only applies to the requirement of the use of an over the counter drug first. The current Step Therapy requirement pertains to other prescription drugs. |
| Data collected | Requests confirmation on whether the description of how to complete the Rate | Rate Table Template | CMS is not proposing any changes to the Rate Table in this PRA package. The explanatory text on row 13 of the Rates Table |

| Comment Type | Comment Summary | Template Area | Response |
|---|---|---|---|
| | Table (Row 13) will be removed. | | Template was inadvertently removed in the previous version of the PRA package and has been restored in the current version. |
| Data collected - Instructions | Suggest that CMS provide additional information at the beginning of the QHP application process regarding what is considered discriminatory. | N/A | This comment is out of scope to this PRA package. CMS provided information regarding potentially discriminatory benefit design in the 2016 Payment Notice. |
| Timeline | Recommends that final PRA package be released as soon as possible. | N/A | CMS will work to finalize the PRA package as soon as possible. |