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Mike Hash
Interim Director
Center for Consumer Information and
Insurance Oversight
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted via the Federal Rulemaking Portal: http://www.regulations.gov

Re: Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans (CMS-9965-P)

Dear Mr. Hash:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to submit comments on the Notice of Proposed Rulemaking ("NPRM") on Essential Health Benefits Data Collection Standards and Accreditation for Qualified Health Plans ("QHPs") published June 5, 2012, in the *Federal Register* (77 Fed. Reg. 33133). The NPRM establishes data collection standards necessary to implement aspects of the Patient Protection and Affordable Care Act ("ACA") which directs the Secretary of Health and Human Services ("HHS") to define essential health benefits ("EHB"). The NPRM outlines the data to be collected from certain issuers to support the definition of EHB and also establishes a process for the recognition of accrediting entities for purposes of certification of QHPs.

BCBSA is a national federation of 38 independent, community-based, and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for 100 million members – one in three Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program ("CHIP"), and the Federal Employees Health Benefits Program.

Regarding the data collection process, BCBSA appreciates that the NPRM seeks to collect sufficient information on potential benchmark plans' benefits to be used by HHS and eventually states, exchanges, and issuers to define, evaluate, and provide the EHB in the individual and small group markets in 2014. However, as proposed, the NPRM raises several issues, challenges, and concerns pertaining to the types of data elements these selected issuers may be required to submit. In particular, we are concerned that the data HHS has proposed to collect appears to exceed the information that is necessary for HHS to define the EHB benchmark plan and for other issuers to establish products with similar benefits. While some of

the detailed information proposed may be necessary when states and HHS try to determine if a proposed product meets the requirements for a QHP, the data requested for identifying and defining EHBs go far beyond information on benefits/covered services and include information that is not relevant for a state in defining its EHB package. Please see our detailed comments below for specific areas of concern.

The EHB data collection processes proposed in the NPRM and the subsequent Paperwork Reduction Notice are cumbersome, complex and burdensome. Issuers of potential benchmark plans will need to expend considerable time, effort, and expense, far in excess of the four hour estimate set forth in the NPRM, to collect, verify, and submit the data requested. The medical policy related elements – which are not necessary for the purposes of establishing benchmark EHB standards – are especially burdensome. As a result, issuers will need substantially more time to collect the proposed information than the August 2012 collection deadline set forth in the related Paperwork Reduction Act ("PRA") Notice[1]. While the PRA Notice collection activities are being proposed as a separate solicitation, they have numerous implications on the NPRM so we have incorporated relevant high level feedback on those, while we also plan to comment in detail on the PRA prior to the August 5, 2012 deadline.

Additionally, we are concerned that HHS is requesting comments on the EHB data collection process without issuing final guidance on the EHB Bulletin. It is critically important to finalize all of the regulations – following the formal, proposed rulemaking process – so that issuers can make all the significant business and information technology changes needed to be ready for the October 1, 2013 open enrollment period. Issuers should not be expected to implement multi-million dollar changes and conduct laborious data collection efforts based on informal guidance that can be subject to changes in a final rule as this will only result in an inefficient use of resources and drive up the cost of coverage.

We continue to believe that the data elements required for defining EHBs should:

- Consider the administrative burden, proprietary issues, and necessity of the proposed data collection approach by limiting the data collection to include only those items necessary for EHB and specifically omitting the requirement for issuers to submit data elements on medical policy and prescription drug formulary.

- Support the use of enrollment data submitted to Healthcare.gov to serve as the source of product enrollment data for determining the benchmark plan; however, in the event where a state believes there is a discrepancy, HHS should work with States to reconcile the inconsistencies in the small group market product enrollment data for the particular state.

- Defer to states to collect data on EHBs and for state's that have already determined their benchmark plan option, limit the data collection to that specified plan.

- Rely on only covered benefits data by using any of the three largest small group insurance products versus plans in the state's small group market for purposes of

[1] Health Insurance Web Portal PRA Package (OCN: 0938-1086) June 1, 2012. Available at https://www.federalregister.gov/articles/2012/06/05/2012-13480/agency-information-collection-activities-proposed-collection-comment-request

defining the EHBs if the covered services across the plans within the product are the same.

Regarding the accreditation of QHPs, we support HHS's proposal to recognize accrediting entities on an interim basis to meet the ACA's tight timelines. However, we recommend making a number of changes to improve the administrative efficiency and effectiveness of the accreditation process. We urge HHS to:

- Set a definitive time for ending the interim phase one process for recognizing accrediting entities – when competition among accrediting entities will be limited – and take steps to make sure pricing is fair.

- Explicitly consider in the formal phase two the direct and indirect costs of the accreditation programs offered by entities seeking to be recognized.

- Ensure that the final accreditation process aligns with previous guidance calling for a phased approach to reporting clinical quality measures to Exchanges and, in the Federally Facilitated Exchange, to accrediting entities.

- Direct all accrediting entities to use a uniform core set of clinical quality measures, which would also be the measures used by Exchanges for quality reporting purposes.

- Take a modular approach to the level of accreditation: at the level of the QHP issuers for policies and procedures that span all products; at the level of the QHP product type for performance.

- Clarify that Exchanges may not collect member-level data if given to accrediting entities.

BCBSA's detailed comments and recommendations on the NPRM follow:

I. Collection of Essential Health Benefits Data

A. Omit the Requirement for Issuers to Submit Data Elements Regarding their Medical Policy and Prescription Drug Formulary *§ 156.120(b)*

Issue: The NPRM proposes that relevant issuers of applicable plans submit certain benefit and administrative data to be used by HHS and eventually states, exchanges, and issuers to define, evaluate, and provide the EHB. HHS proposed that relevant issuers submit data in four areas: (1) administrative data necessary to identity their health plan; (2) covered health benefits; (3) treatment limitations imposed on coverage; and (4) prescription drug coverage, including a list of covered drugs and information on whether each drug is subject to prior authorization and/or step therapy.

Recommendation: Omit the requirement for issuers to submit data elements regarding certain treatment limitations. Additionally, do not require issuers to submit data elements regarding prescription drug formulary. Finally, ambiguous, "catch-all" categories, such as "other" should be avoided. At a minimum, the following data elements should not be collected:

- Referral(s)

- Prior authorizations
- Non-quantitative limits
- Prescription drug formulary
- Health benefits containing the term "other"

Rationale: The data collection approach appears to exceed the amount of information that is necessary for HHS to define the EHB benchmark plan and attempts to collect information that is either not relevant for indentifying benefits in the EHB benchmark plan, are not readily available, require significant levels of effort to collect, and involve the collection of sensitive proprietary business information. While the data collection appears to be applicable for QHP certification purposes, that effort should be proposed under a separate solicitation at a later time.

Furthermore, the EHB benchmark approach should only define the types of services that are covered, and not dictate the way services are covered such as place of treatment, referral requirements, and prior authorizations. Conflating the process for determining the scope of benefits and the process for making significant coverage decisions may undermine issuers' ability to ensure that patients receive the right care at the right time and result in a one-size-fits-all approach to care that fails to recognize the unique needs and circumstances of particular individuals. In addition, it may contribute to higher utilization which in turn would increase the cost of health care and ultimately result in fewer people being able to afford coverage.

Finally, requiring selected issuers to turn over large quantities of proprietary and confidential data beyond what is necessary for the purpose of establishing the standard for a state's EHB package risks inappropriate disclosure of information which is either proprietary or which would be difficult for competitors to obtain in the absence of a standard information request for these selected issuers. Relevant to our concerns here are considerations for the potential inadvertent or improper release under the Trade Secrets Act and Freedom of Information Act, as well as additional risks associated with information in the public domain being combined with agency public use files or other disclosures in a way that creates market competition and privacy concerns since only selected issuers will have to provide this detailed information at this time.

Our concerns with specific data elements are highlighted below:

1. Benefit Limitation Data Elements

There are literally thousands of variations of coverage for any single insurer and the administrative burden of reporting all of the situations under which prior authorizations, referrals or non-quantitative limits are required would be significant. For example, a cortisone injection in the knee by an orthopedist typically would not require prior authorization whereas many issuers require a prior authorization for orthovisc or synovisc injections, high cost injections that restore joint fluid in persons with osteoarthritis, to be injected into the same area of the knee. This is just one of many examples that could be listed under an orthopedist specialist office visit and there are other countless examples that would apply to other specialties for services provided by primary care physicians and other providers (e.g. therapists, outpatient surgeries, etc).

Likewise, listing out instances where referrals and non-quantitative limits are required is also not necessary for defining EHBs and would require detailed reporting of the medical policies that apply to each place of treatment, provider credentialing, and provider reimbursement, etc. The language in 45 CFR 146.136 (c)(4)(ii) provides an illustrative list of non-quantitative treatment limitations, including:

A. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
B. Formulary design for prescription drugs;
C. Standards for provider admission to participate in a network, including reimbursement rates;
D. Plan methods for determining usual, customary, and reasonable charges;
E. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols); and
F. Exclusions based on failure to complete a course of treatment.

These criteria are not relevant to defining EHBs and if used for EHB purposes would have significant negative ramifications. For example, if the benchmark plan is a preferred provider organization (PPO) product without referrals, what impact would that have on a staff model health maintenance organization (HMO) plan and its ability to require referrals? Additionally, categories such as provider reimbursement rates are proprietary and should be protected from public release.

In the PRA Supporting Statement, HHS estimates that it would take one employee four hours to meet the proposed reporting requirement, which as proposed, is well under-represented given the thousands of variations of coverage for any single issuer and the administrative burden of reporting all the situations under which prior authorizations, referrals or non-quantitative limits are required, the processes surrounding the data collection, and the time needed to verify the information. We estimate that the time required to collect the proposed data elements could take several weeks to complete and would require input from multiple employees due to the specialized expertise in the various benefit areas such as medical, mental health, prescription drug, etc. Including the data elements listed above would result in exponentially more effort than the four hours noted in the PRA and would result in issuers being unable to meet the August 2012 deadline as proposed in the PRA. However, should HHS decide to remove these data elements from the proposed reporting requirements, then the PRA estimate would reflect a more appropriate level of effort. While we do not support the collection of non-quantitative limits, we do support the collection of quantity limits given their role in calculating and ensuring actuarial value and equivalence.

If the purpose for capturing medical policy fields is to ensure consumer transparency, then this is not relevant for defining EHBs and a better way to approach this in the future would be to have all plans post their medical policy online as the majority of issuers do today. This would allow consumers to see specific procedures or conditions that apply to them in their entirety, versus obtaining summary data that may not be helpful. This also would significantly reduce the administrative burden and costs for issuers while providing more meaningful information to consumers and their providers.

Additionally, under the ACA, plans are prohibited from imposing annual and lifetime dollar limits on EHBs. However, plans are still permitted to impose non-dollar limits. BCBSA is concerned that by collecting data on benefit limitations, HHS may be planning to limit plan flexibility by potentially requiring the market to have prior authorizations that exactly match what's offered in the benchmark plan. In this regard, we believe that the requirement to provide data on benefit limitations such as prior authorizations, non-quantitative limits, and referrals go far beyond statutory requirements and may have the unintended consequence of compromising payers'

abilities to ensure safe, affordable, and customized care, leading to a one-size-fits-all approach to care that fails to take into account the distinct needs and conditions of certain individuals.

To provide an example of the proper level of product detail on the covered services while also minimizing the associated administrative burden of reporting such covered services, BCBSA has developed a data collection template that can serve as a model for HHS to follow for their future EHB data collection efforts. We believe that this template provides the necessary level of specificity to define, evaluate, and provide the EHBs and have attached the template in Appendix 1.

Lastly, from a technical perspective, we recommend that issuers report "exclusion" information in a separate section rather than for each individual benefit, as many exclusions tend to overlap multiple benefit categories. For instance, plastic surgery exclusions could apply to primary care visits, specialist visits, outpatient surgery, inpatient surgery, etc. Since exclusions are not mutually exclusive across the benefit categories, we suggest having them reported as a separate and distinct element.

2. Prescription Drug Data Elements

In addition to select benefit limitation data elements, prescription drug formulary data elements should not be required for the purposes of defining EHBs. Compiling this information would require a significant level of effort and does not appear to serve any purpose for defining the EHB benchmark. There are already minimum formulary requirements and for EHB purposes, issuers should be required to meet those requirements while having the freedom to design their formularies and use managed care techniques in order to control costs. Furthermore, information falling in this category includes some of the most competitively sensitive information and the collection and disclosure of this information prior to any requirement that all issuers report this information may substantially place the selected plans at a competitive disadvantage. Relevant to our concerns here are considerations for the potential inadvertent or improper release under the HIPAA Privacy Rule, Trade Secrets Act, and Freedom of Information Act, as well as additional risks associated with information in the public domain being combined with agency public use files or other disclosures in a way that creates market competition and privacy concerns.

3. Health Benefit Data Elements

Finally, "catch-all" categories such as "other relevant data" and "other" benefits should be avoided as issuers do not know the level of granularity that is required to complete this field and it is virtually impossible to list every service that is covered. We also recommend that additional clarity be provided around the data requirements to fulfill the "benefit description" field.

Simply put, all data collections need to be evaluated for their necessity, as well as the burden and cost placed on the issuers. As described above, the data collection requirements as currently outlined create a significant amount of burden on issuers which in turn will increase health plan administrative costs at a time when issuers seek to lower their administrative costs to meet medical loss ratio requirements and maintain affordability of options in the marketplace. Furthermore, the data that HHS is requiring issuers to submit exceeds the amount of information that is necessary for defining the EHB benchmark plan and we urge HHS to only collect information that is necessary for EHB purposes, and that the Department eliminates the submission of medical policy and prescription drug data elements. This will ensure that the data collection approach is:

1. Efficient and takes into consideration the complexity of the data elements and the level of effort to collect the required fields;
2. Appropriate and serves the correct purpose of only defining the EHB package; and
3. Proprietary and takes into account the confidentiality of competitively sensitive information.

B. Support the Use of Enrollment Data Submitted to Healthcare.gov to Serve as the Source of Product Enrollment Data for Determining the Benchmark Plan *§ 156.120(c)*

Issue: Because state data may vary from Healthcare.gov data, HHS is seeking comments on whether states should be permitted to use an alternative data source for determining the enrollment in the small group market.

Recommendation: Support the use of enrollment data submitted to Healthcare.gov to serve as the source of product enrollment data for determining the benchmark plan; however, in the event where a state believes there is a discrepancy, HHS should work with States to reconcile the inconsistencies in the small group market product enrollment data for the particular state

Rationale: On July 2, 2012, HHS released a list of the largest three small group products by state using March 2012 enrollment data submitted to Healthcare.gov. While BCBSA supports the use of enrollment data submitted to Healthcare.gov to serve as the source of product enrollment data for determining the benchmark plan, HHS should work with States to reconcile the inconsistencies in the small group market product enrollment data for the particular state in the event where a state believes there is a discrepancy. This will ensure a consistent, nation-wide benchmark selection approach that is free from potential political forces.

C. Support the Exclusion of Association Products as Options in the Selection of the Largest Three Products *§ 156.120(c)*

Issue: Under the approach outlined in the December 16, 2011 EHB Bulletin, states would be permitted to select their own benchmark plan from a set of options. HHS is seeking comments on whether closed block or association products should be included as options in the selection of the largest three products. On July 2, 2012, HHS released a list of the largest three small group products by state that included closed but active products and excluded association products.

Recommendation: Support the exclusion of distinct association products with their own product ID number in HIOS as options in the selection of the largest three small group products.

Rationale: We are pleased that HHS has excluded distinct association products in their July 2nd release of the largest three small group products in each state, as association products do not cover many of the EHB statutory categories, including preventive services. While HHS has included closed but active products in the list of the largest three small group products in each state, we are currently evaluating the impact of including closed block products as options in the selection of the largest three products and will provide more detailed comments in our response to the PRA Notice on EHBs prior to the August 5, 2012 deadline.

D. Defer to States to Collect Data on EHBs and if a State has Already Determined its Benchmark Plan Option, Only Collect Data from that Plan *§ 156.120(d)*

Issue: The NPRM proposes that HHS collect data from the issuers in each state that offer the three largest health insurance products, by enrollment, in that state's small group market.

Recommendation: Defer to States to collect data on EHBs and for State's that have already determined their benchmark plan option, limit the data collection to that specified plan.

Rationale: Many states have already collected information from issuers in the state to identify the benchmark plan and to define the EHBs within that plan. Therefore, HHS should not collect any additional information, unless the state deems it necessary to supplement the information already collected to inform any necessary supplementation for one of the 10 benefit categories. Furthermore, for states that have identified their benchmark plan option, data collection efforts— incorporating the recommendations from above— should be limited to that particular plan versus all eligible benchmark plan options.

Furthermore, once a state has selected its benchmark, it should use the optional template included in the PRA request package to inform HHS of its selection.

If a state does not select a benchmark plan in a timely fashion, HHS should collect data as proposed in the proposed rule incorporating our recommendations from above. Data collections should be targeted only to the information that is needed and should leverage data already collected by the states and for Healthcare.gov to the maximum extent practicable.

E. Rely on Only Covered Benefits Data by Using any of the Three Largest Small Group Insurance <u>Products</u> Versus Plans in the State's Small Group Market for Purposes of Defining the Essential Health Benefits if the Covered Services Across a Product are the Same for a Particular Issuer *§ 156.120(d)*

Issue: The NPRM proposes that issuers of the largest three products in the State provide information based on the <u>plan</u> with the highest enrollment within the product for purposes of identifying the benchmark plan.

Recommendation: Base the small-group benchmark on any of the three largest small group insurance <u>products</u> in the state's small group market if the covered benefits are the same across plans within a selected issuer's product. In the event that the covered benefits are different across the largest product then the benchmark should be based on the plan with the highest enrollment within the product as proposed in the NPRM.

Rationale: As noted in the NPRM, the benefits across plans within a product are typically the same. Differences between products and plans are largely a function of different levels of cost-sharing. As HHS indicated in its EHB Bulletin, the EHB definition pertains only to the types of services that are covered and not the way services are covered. Thus choosing a benchmark plan based on the product level is the most appropriate, practical and feasible approach. Furthermore, from an administrative standpoint, issuers generally do not report enrollment data to the states or Federal government by "plan" level; instead, it is reported at the "product" level. For purposes of identifying the EHB benefits, we recommend that HHS use any of the three largest small group insurance products in the state's small group market; however, if the

covered benefits are different across the largest product then the benchmark plan should be based on the plan with the highest enrollment within the product as proposed in the NPRM.

II. Accreditation of QHP Issuers

A. Recognition of Accrediting Entity by HHS [Interim Phase One] *§ 156.275(c)(1)*

Issue: HHS proposes to recognize NCQA and URAC on an interim basis for an interim phase one process of unspecified duration. We support HHS's proposal to recognize accrediting entities on an interim basis to meet the ACA's tight timelines. However, necessarily restricting competition to two entities raises significant concerns in what is a captive market for accrediting entities.

Recommendation: HHS should set a definitive time for ending the interim phase one process, so as to limit any negative consequences from the lack of competition. In addition, during the interim period when competition will necessarily be limited, we recommend that HHS monitor the fees that accrediting entities charge – in particular, the fees charged per QHP enrollee – to ensure that the lack of competition does not have negative effects. It may be necessary to place limits on fees that may not be included in the medical loss ratio (MLR) calculation (i.e., fees related to accreditation standards that do not support MLR quality expenses) because otherwise QHPs will experience unfair pressure on their MLR determinations.[2] And HHS should require full transparency from the accrediting entities, to include not only the direct cost of their pricing structures, but estimates based on existing commercial and Medicaid business of the indirect costs of the health plan systems and human resources devoted to survey preparation and related tasks.

Rationale: As we have seen in the case of accreditation organizations for hospitals in the Medicare program, lack of competition has led to frustration not only over the direct and indirect costs of accreditation surveys and fees, but also over the prescriptiveness of standards.[3] The longer the interim phase one process runs, the greater the uncertainty facing other potential accrediting entities who might otherwise seek HHS recognition in the formal phase two process, and the greater the chance that Qualified Health Plans (QHPs) will face higher fees and unreasonable standards.

B. Recognition of Accrediting Entity by HHS [Formal Phase Two] *156.275(c)(1)*

Issue: HHS intends for the future recognition process to include an application procedure, standards for recognition, a criteria-based review of applications, public participation, and public notice of the recognition for entities seeking to become a recognized accrediting entity, and solicits comments to inform this future rulemaking.

Recommendation: To keep down costs, BCBSA recommends that the criteria for review include full transparency in pricing so that HHS may assess the direct costs (fixed and

[2] In an analogous captive arrangement, mandatory external review, some states address cost to plans: MT—carrier will pay reasonable costs of review; NH—carrier will pay costs of external review not to exceed $1,500; TX—two-tier fee system, $650 Tier 1, $450 Tier 2.

[3] Blackmond, B. (February 2009). Hospital accreditation – Alternatives to the Joint Commission. (American Health Lawyers Association).

marginal) and the indirect costs (human and system resources) of the QHP accreditation programs offered by entities seeking to be recognized. To keep up innovation, BCBSA recommends that one standard for recognition be a governance structure that includes a wide range of stakeholders – including providers, health plans, and consumers – and internal processes that are transparent and that seek regularly to engage stakeholders in developing new standards.

Rationale: Two key goals of the recognition process should be to ensure that accrediting entities (1) keep to a minimum the direct and indirect costs of accreditation; and (2) keep up their ability to innovate.

C. Clinical Quality Measures *§ 156.275(c)(2)(ii)*

Issue: HHS proposes that accrediting entities use clinical quality measures that meet five criteria: span a breadth of conditions and domains; include separate measures relevant to children and adults; align with the priorities of HHS's National Quality Strategy; only include measures that are either developed or adopted by a voluntary consensus standards-setting body, or where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet industry standards; and are evidence based. HHS solicits comments whether to include additional standards, and whether accrediting entities should review specific clinical quality measures as part of accreditation. However, in contrast with the November 2011 guidance and the May 2012 General Guidance on Federally Facilitated Exchanges that calls for transitioning in a clinical quality measure set, the proposed rule is silent on the need for transitioning in clinical quality measures.

Recommendation: To minimize administrative burden and data collection costs, clinical quality data reported to accrediting entities should be aligned to the maximum extent feasible with the clinical quality data to be displayed by Exchanges for quality reporting purposes under ACA sec. 1311(g) as well with Federally Facilitated Exchanges. Therefore:

- ***Recommendation C1***: We recommend that HHS direct that accrediting entities follow the same transition pathway in using the clinical quality measure set as HHS has already proposed in previous guidance.

  Rationale: In "State Exchange Implementation Questions and Answers," (November 2011), HHS "intends to propose a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, transitioning to a QHP-specific rating in 2016." Following a similar timeframe, in General Guidance on Federally Facilitated Exchanges (May 2012), HHS proposes that "QHP issuers without existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification" – meaning that QHP issuers would not have to submit performance data to determine metrics such as HEDIS or CAHPS. In our comments on guidance for Federally Facilitated Exchanges, we urged HHS to require that accrediting entities defer using a full set of clinical quality measures until 2017, to allow sufficient time to validate data and metrics and to enroll enough members for adequate sample sizes. In 2016, only a minority of clinical quality measures would be ready for use, and accrediting entities should use those measures for reporting only, not for accreditation

scoring. We believe the same timeframe should apply to use of the proposed clinical quality measure set.

- ***Recommendation C2***: We recommend that all accrediting entities use a common, core set of clinical quality measures – and a common set of auditing procedures to ensure data integrity – that will also be used for quality reporting and rating. As a start, the core set should include HEDIS measures that are NQF-endorsed.

  Rationale: Using the same set of well-defined, nationally accepted HEDIS measures for all of these purposes – drawn from the core set used across recognized accrediting entities – will minimize the burden and expense of data collection and enable more expeditious implementation of these provisions. To the extent possible, in developing the core measure set HHS should minimize administrative burden and expense of data collection by relying on administratively-derived measures. Measures that rely on a hybrid data collection methodology lead to substantial costs and administrative burden of manual chart review.

D. Level of Accreditation *§ 156.275(c)(2)(iii)*

Issue: HHS proposes that accrediting entities provide accreditation at the Exchange product-type level (for example, Exchange HMO, Exchange POS, Exchange PPO) as it would balance capturing the QHP experience and enabling the reporting of valid and reliable performance measures. Presumably, the reasoning behind this statement is that if an issuer offers multiple QHPs under the same product type, any one QHP may not be able to generate – at reasonable cost and on an acceptable timeline – a sufficient sample for calculating valid and reliable metrics, hence the advantages of aggregating QHPs by product type.

Recommendation: Accrediting entities should provide accreditation of health plan policies and procedures at the level of the QHP issuer, and accreditation of performance at the Exchange product type level. This "modular" approach would substantially streamline accreditation processes, mitigating non-value-added administrative costs that drive up premiums. Savings would stem not only from reducing issuers' staffing and other resources devoted to redundant policies and procedures accreditation, but also from lower accreditation fees enabled by greater economies in evaluating issuers' enterprise-wide policies and procedures once – and not each time an issuer seeks to offer a QHP product-type in a given Exchange.

At a minimum, issuer-level accreditation on policies and procedures should apply across product types offered within state Exchanges. Additionally, if health plans' policies and procedures are consistent inside as well as outside of Exchanges, HHS should assure coordination between Exchange and non-Exchange accreditation; in these instances, accreditation on non-Exchange policies and procedures also should fulfill Exchanges' issuer-level policies and procedures module.

Rationale: Although the preamble gives examples of product type, neither this proposed rule nor any final Exchange rules define product type, leaving open the possibility that an Exchange may define multiple product types, which would make the accreditation process more costly and resource-intensive for issuers. Moreover, although it would be appropriate for accrediting entities to assess standards related to performance at the product type level, it would make

little sense to assess a QHP issuer's policies and procedures that are common across all product types in a separate product type-by-product type accreditation.

E. Documentation *§ 156.275(c)(4)*

Issue: HHS proposes that accrediting entities submit to HHS any proposed changes/updates to accreditation and measurement process with 60 days notice prior to implementation. However, the proposed rule is silent on providing similar advance notice to QHP issuers.

Recommendation: Clarify that HHS will continue current industry practice by accrediting entities of providing one year's advance notice of changes in the accreditation and measurement process to health plans. Further, we recommend that during the proposed 60-day period, HHS seek input from affected stakeholders in determining whether any proposed changes or updates are significant enough to mean that the conditions in § 156.275(c)(2) and (3) would no longer be met.

Rationale: Maintaining consistency with current practices will avoid unnecessary administrative costs.

Issue: The proposed rule notes that the 60-day advance notice requirement will assure that HHS has ample opportunity to review and comment on accrediting entities' planned changes and updates, it does not address HHS's turnaround time when accelerated review is necessary to correct an error or clarify an ambiguous requirement that is causing marketplace confusion.

Recommendation: Clarify that under certain circumstances the agency will rapidly review and respond to the proposed modification.

Rationale: Certain circumstances may demand rapid review, such as when an accrediting entity needs to make an immediate revision or update to its accreditation program.

F. Data Sharing Requirements *§ 156.275(c)(5)*

Issue: HHS proposes that when authorized by an accredited QHP issuer, recognized accrediting entities provide certain accreditation survey data elements to the Exchange, including clinical quality measure results and adult and child CAHPS measure survey results (and corresponding expiration dates of these data) at the level specified by the Exchange. As examples of level, the Preamble offers product or plan level. It does not include member-level data. However, nothing in the proposed rule would prevent Exchanges from requiring the member-level records that were used to score the aggregate clinical quality measure or survey measure results.

Recommendation: Clarify that data should only be shared at the aggregate/summary level, consistent with the intent of HHS's examples in the Preamble. This would be analogous to the way the Integrated Healthcare Association (CA) collects quality measure results from Plans – with NCQA as an intermediary – to calculate physician performance scores for use in multi-payer pay-for-performance. Such a model prevents the movement of member-level data containing sensitive personal health information (PHI) that, when transmitted across entities

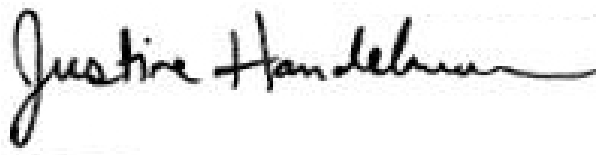
and duplicated in a new repository, is vulnerable to privacy and security risks that could be avoided by retaining data at its original site and sharing only aggregated results.

Furthermore, summary data (e.g., numerators and denominators for clinical quality measures) will furnish the Exchange with the necessary information to fulfill additional quality-related functions, such as administering health plan quality reporting and rating.

* * *

We appreciate your consideration of our comments. We look forward to continuing to work with HHS on implementation issues related to the Affordable Care Act. For questions related to EHB data collection, please contact Richard White at (202) 626-6813 or at richard.white@bcbsa.com. For questions related to the accreditation of QHPs, please contact Joel Slackman at (202) 626-8614 or joel.slackman@bcbsa.com.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

cc: Sherry Glied, Ph.D., Assistant Secretary for Planning and Evaluation, HHS