Comment:

We proposed in the notice of proposed rulemaking that issuers may use their own data to determine the benchmark approach described in the EHB bulletin. In response to comments, we have revised our proposal so that issuers will use the data published by the state health insurance exchanges.

Response:

We believe it is necessary to collect additional information that is not currently available from the EHB bulletin, including:

- Additional drug data
- Additional data on treatment limits
- A more extensive therapy coverage

In order to address these concerns, we have proposed a process for issuers to submit information to HHS, including data on covered health benefits and other descriptive information.

Comment:

Initial data collection is being conducted in a pilot program for the five largest markets, with the results to be published in HealthCare.gov.

Response:

We are continuing our efforts to gather additional information on covered health benefits. We have also made revisions to the proposed regulation to address concerns raised by commenters.

Comment:

The definition of benchmarking in this proposed rule is not clear. Could it be interpreted as the highest cost plan in a market? Does it mean the plan with the lowest cost?

Response:

The definition of benchmarking in this proposed rule refers to the process of identifying the largest three plans in each market area. This includes plans in the individual and small group markets that are the highest cost options.

Comment:

Does the rule require issuers to submit information on covered health benefits separately from the EHB regulatory proposal?

Response:

The rule requires issuers to submit information on covered health benefits separately from the EHB regulatory proposal. This information will be collected separately from the notice of proposed rulemaking.

Comment:

The definition of benchmarking in this proposed rule is not clear. Could it be interpreted as the highest cost plan in a market? Does it mean the plan with the lowest cost?

Response:

The definition of benchmarking in this proposed rule refers to the process of identifying the largest three plans in each market area. This includes plans in the individual and small group markets that are the highest cost options.

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Comment:

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Response:

The definition of benchmarking in this proposed rule refers to the process of identifying the largest three plans in each market area. This includes plans in the individual and small group markets that are the highest cost options.
We received numerous comments in support of the proposed 60 day timeframe for documentation submission. We finalize in this rule that the documentation from recognized accrediting entities may review policies and procedures regarding essential community providers as part of its current accreditation process. This change does not affect the QHP certification standard that QHPs must meet. However, in its comment on the proposed rule that the recognized accrediting entities may review policies and procedures regarding the QHP issuer’s network adequacy assessment, the commenter believes that this is inherently a regulatory action and should not be delegated to private accreditors. The commenter believes that this is inherently a regulatory action and should not be delegated to private accreditors. The commenter believes that this is inherently a regulatory action and should not be delegated to private accreditors.

In this final rule, we are maintaining the standards that we proposed for clinical quality measure standards to include domains such as outcomes and process apart from access to care. We clarify that URAC’s publicly released Health Plan Accreditation Standards include quality measures to include domains such as outcomes and process apart from access to care. We agree that NQF plays a significant role in endorsing quality measurement tools and has endorsed measures to include domains such as outcomes and process apart from access to care. We are finalizing the requirement that the recognized accrediting entities require accreditation on local performance in patient experience ratings as a part of the accreditation process, increasing competition. We acknowledge that NCQA does not currently capture information regarding the quality requirements on Exchanges and health insurance issuers. The commenter recommends that states should have the authority to require entities seeking recognition as accrediting entities to review clinical quality measure standards to include domains such as outcomes and process apart from access to care. The commenter also suggested that HHS require accrediting entities to review health plan clinical quality measure standards to include domains such as outcomes and process apart from access to care.

We proposed in §156.275(c)(4) that each accrediting entity recognized by the Exchange, which is subject to the accreditation survey requirements and conditions in §§156.275(c)(2) and 156.275(c)(3), would no longer be met. The commenter suggests that the clinical quality measure standards included in the medical loss ratio calculation. The commenter believes that the recognition process for new quality reporting and display requirements.

The statute specifically directs that QHPs be accredited and that the QHP issuer be accredited on the basis of the standards that meet the statutory requirements and that specifically address persons in need of culturally competent services. A few commenters requested HHS to clearly distinguish the broader phase one process for new quality reporting and display requirements from phase two recognition process requirements for recognized accrediting entities. A few commenters requested HHS to clearly distinguish the broader phase one process for new quality reporting and display requirements from phase two recognition process requirements for recognized accrediting entities. We are maintaining the standards that we proposed for clinical quality measure standards to include domains such as outcomes and process apart from access to care. We are finalizing the requirement that the recognized accrediting entities require accreditation on local performance in patient experience ratings as a part of the accreditation process, increasing competition. We acknowledge that NCQA does not currently capture information regarding the quality requirements on Exchanges and health insurance issuers. The commenter recommends that states should have the authority to require entities seeking recognition as accrediting entities to review clinical quality measure standards to include domains such as outcomes and process apart from access to care.

We propose in §156.275(c)(4), we proposed that each accrediting entity recognized by the Exchange (for example, QHP product or plan level).

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3. INCLUDING STANDARDS RELATED TO EXCHANGES

Pursuant to the requirements set forth in section 8(a) of this Act, issuers must report information from the issuers.

That requirement are likely to be minimal because the states are likely to obtain this information.

The plan would be required to submit their benchmark plan selection to HHS, and work cooperatively with affected states, including participating in conference calls.

We cannot reasonably anticipate how many states will respond.

This rule authorizes a narrow data collection from an estimated 13,900 issuers. In 2012, that threshold is approximately $139 million.

This rule would not have a significant economic impact on a substantial number of small businesses.

We have included a cost-benefit analysis of the rule.

A regulatory impact analysis (RIA) must be prepared for major rules. We derived the costs and benefits as outlined below.

We do not anticipate that there would be any costs associated with this rulemaking in addition to those costs, as outlined below.

On August 5, 2012, and we encourage interested parties to submit comments.

That comment period closes on August 1, 2012, and we encourage interested parties to submit comments.

ICRs described in the proposed rule. As described above, although we made some changes to § 156.275(a)(2), we did not change the requirement to submit the data.

We received some comments on this.

We will further clarify the process including definitions of data elements.

We will also make changes to § 156.275(c)(4)(i) and § 156.275(c)(5) with Exchanges.

We have made changes to § 156.120(a) to require issuers to maintain records of data and transactions.

Comment:

One commenter requested clarification regarding what is meant by the term, “Portal Plan” in § 156.275(c)(4)(ii).

We disagree with this comment.

We have included the definition as follows:

“Portal Plan” means benefits for medical care, as defined at § 156.275(a)(2), QHP issuers will authorize the release of.

We made changes to § 156.275(c)(4)(iv) to require issuers to maintain records of data and transactions.

We agree with the commenters’ comments.

One commenter requested more information regarding the process described in paragraph (a)(1) of § 156.275(c)(5).

We have included the following:

- Methodological and scoring criteria for accreditation.
- Documentation.
- Comment:

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According to the Small Business Administration size standards, entities with average annual receipts of $7 million or less would be considered small entities under the Small Business Administration size standards for North American Industry Classification System (NAICS) Code 524298 (All Other Insurance Related Activities) (for more information, see “Table of Size Standards Matched To North American Industry Classification System Codes,” effective March 26, 2012, U.S. Small Business Administration, available at https://www.sba.gov).