DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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DATE: May 16, 2011

TO: Issuers of Health Insurance

FROM: Doug Pennington
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SUBJECT: Reply to Comments, Information Collection Request for HealthCare.gov
OMB Control # 0938-1086

We want to thank those who provided comment on our emergency information collection request. CMS received four replies, three of which address the actual data collection and one comment that did not address the topics raised in the PRA. While the commenters presented very different perspectives on the collection, they raised salient points. Certain common themes were present, and CMS will be taking steps to address them, including: the cost of data collection, the elimination of redundant or unnecessary data elements, confidentiality protections, and coordination of collections moving forward. These areas are addressed below.

Cost of the collection:

Two commenters suggest that the costs of complying are higher than stated in the PRA notice. One comment notes that we collect through two different systems, while the other mentions the scope of data. Neither comment provided specific new information on why the costs are high. CMS is committed to continuously improving the system to reduce the costs on submitters, and is currently reviewing the systems and contracts underlying the collection to this end.

Planned improvements include better integration of the collection instruments for products and portal plans, as well as development of more automated data collection methods including XML standards and APIs for electronic data exchange. One improvement that we have implemented as a result of similar concerns is to use date based rates, which will allow us to decrease the number of updates. We will emphasize the importance of "pre-populating" data in templates moving forward to decrease data entry times. We also plan to incorporate template designs which allow for increased flexibility in data entry requiring less reliance on custom adaptations.

One comment contends that their projected costs are significantly higher than the average presented in the PRA support materials, and recommends decreasing the number of elements collected. We are committed to reducing the burden on issuers, and note that CMS collects only a few elements which are not currently collected by third party vendors engaged by the industry. We believe that cost savings can best be realized not by scaling back data elements, but rather through process improvements which we are implementing and/or planning. As the commenter indicates, their costs are compounded by short time frames, and certain inefficiencies in the collection process which we are addressing.

One commenter also mentions inadequate granularity for data elements to reflect actual company practice. In general, there is some tension between providing standardized categories for answers and reflecting actual practices. CMS plans to continue scheduled conference calls, the PRA process, and email to address these types of concerns as they arise. CMS is dedicated to continuous improvement and is currently reviewing data element operationalizations.

Information collected and not used:

Two commenters mention that data is collected which is not displayed on the web site. We note that this is not due to "monitoring" activities as such, but generally reflect specific application needs for the current site as well as planned improvements.

The first specific elements mentioned are closed blocks of business. The collection of closed block information gives CMS notice on what products issuers are licensed to sell. This is the only way to define the universe for purposes of the data collection, and we collect very limited information on these: knowledge of these lines of business and their enrollment. This facilitates general compliance with the regulation and helps to convey why we only have a small percentage of the covered lives represented within the plans on offer.

Additionally, collecting this information helps maintain continuity in the population of plans and products over time. "Closed Blocks" is a term of art, with issuers rotating blocks of business in and out of the market. Not including closed blocks of business because the product is not being actively marketed would mean that it is impossible to adequately represent the full universe of products and plans to consumers. Finally, collecting this information to populate the entities offered to the public will help coordinate this data collection with other requirements of the ACA moving forward.

Two commenters indicate a number of data elements are collected and not displayed, such as financial ratings. We do plan on displaying financial rating information or links to the appropriate rating firm for companies within corporate profiles. There are some data elements which are included in the collection primarily as residual elements from the commercial templates we took as our model. These include logos and written corporate descriptions which are not displayed. CMS is contemplating including this information on future company profile pages on HealthCare.gov moving forward, and would like to use these elements in user testing to determine the most consumer and corporate friendly presentation. Nevertheless, the elements are not critical to the current data collection and should be considered voluntary. CMS will make sure issuers recognize those elements (and elements which are duplicated across templates) are voluntary and not required.

Availability of materials elsewhere

One commenter notes that much of the information collected is available elsewhere, for example plan brochures. CMS recognizes that much of the information is available on third party vendor sites, issuer web sites, SERFF filings and associated State regulatory pages. However, the specific statutory mandate of the PlanFinder application of the site, and the value of the site, is to provide a single location where consumers receive sufficient information to determine the range of affordable care options available to them. Our approach has been to collect the information in a consistent comparable fashion, and link consumers to specific details (such as brochures and premium quotes) through linking to the issuer web sites.

There are a few key differences from commercial sites which we believe make the data collection worthwhile for both the public and insurers. First, we estimate that only 50% of issuers use these commercial sites. Coverage and representation of options on those sites is not

standardized and doesn't present the full range of affordable options, representing particular marketing efforts. CMS collects some additional data elements which contextualize the information for consumers, and requires reporting of open plans that represent a significant share of enrollment.

Specific elements were identified which the commenter contends should be provided solely by insurer's own websites without further explanation, including : plan enrollment, additional coverage, dental benefits, medical records coverage, and chiropractic, mental health and substance abuse treatment services. We note that these elements are not standardized across web sites, making them impossible for consumers to compare. The specific benefit coverage types are all suggested by the NAIC for inclusion in the Summary of Costs and Coverage, and the mental health and substance abuse treatment services have been singled out for particular notice by various consumer groups and SAMHSA as difficult to find in issuers' current materials.

Confidentiality

CMS recognizes the importance of confidentiality and is currently engaged in discussions to determine better ways to make sure industry concerns are being met. All three commenters address a concern with the release of what they consider to be confidential business information through Freedom of Information Act requests. Factors listed as potentially confidential included enrollment levels, rating factors, citizenship requirements, eligibility requirements, rate update timing, categorical conditions for membership, administrative fees, rating tiers, and minimum contribution requirements for small group plans, applications, uprated offers and denials.

While CMS contends that prior FOIA requests were responded to in the proper manner, we acknowledge that industry still has concerns and we are in regular discussions with industry representatives to assure we fully understand and address those concerns within the scope of our authority and the law.

Integration of data collection under the ACA:

Two comments raised a concern regarding data coordination under the ACA moving forward. CMS is dedicated to this effort as well. The CCIIO teams responsible for various provisions of the ACA at CMS have recently chartered a Data Steering Committee to make sure those involved in these efforts coordinate moving forward. We are currently engaged in defining a metadata repository which will allow for concrete mapping of entities reducing the likelihood of conflicting definitions and duplicative data collection. CMS has recently incorporated a CCIIO representative to the CMS Data Governance Board to increase coordination with other federal efforts as well.

HealthCare.gov will continue to serve as a focal point for additional collections outside the specific scope of the exchanges. We believe that by anticipating certain needs and maintaining a degree of flexibility in the HealthCare.gov collection, we believe we can take further steps to decrease the burden from forthcoming data collections. The Health Information Oversight System (HIOS) which is used to collect issuer and product data currently is intended to serve as our primary collection instrument. Contracts are currently being revised and generated to improve this process and expand it to cover other ACA requirements and eventually all 1103 data collection may be collected through HIOS.

We believe that additional discussions, to include insurance industry representatives, are appropriate regarding the overall structure of future implementations, but note that we are under statutory guidelines which require continued provision of affordable health care information on HealthCare.gov. The emergency clearance requested for the current PRA was due to a set of

outstanding questions regarding other data collections, and a regular PRA process has begun which will incorporate guidance being developed under section 2715 for transparency data to include a standardized Summary of Costs and Benefits. We believe we are clearly incorporating the primary points identified by the commenters as elements for an integrated framework.

Goals of the web portal/plan finder

One comment takes issue with the fundamental purpose of the site, arguing we should list companies, what types of insurance they sell, and provide links to the primary company web sites. CMS contends that Congress intended through section 1103 of the ACA to provide consumers with access to consumer friendly information about available affordable health care options, requiring the ability to assess the affordability of those options. Additionally, we note that Congress did not include an end date of 2014 despite the opportunity to do so, and that Congress included other mentions of the web portal in other provisions which would appear to suggest an expanded role – specifically section 2715 and 2715A covering transparency. Congress did not deny HHS the opportunity to utilize the web portal in assisting issuers to meet other reporting provisions should this prove cost beneficial to the agency or issuers.

While HealthCare.gov is the first centralized collection of this information for all issuers, and does allow a single point for reviewing information, we wish to note that we have only very minimally increased the number of elements being collected beyond those used for commercial sites. Centralization, standardization, and inclusiveness make HealthCare.gov qualitatively different from what is currently available in the marketplace.

The web site warnings regarding the timeliness and accuracy of rates are standard practice, and do not suggest that base rates are erroneous. Base rates allow for comparison, and uprate and denial data provide context by which the consumer can understand the likelihood that they will receive those base rates offers. HealthCare.gov is the only site to provide such context. We include processes for attestation as well as issuer review, and have been able to respond to the few concerns issuers have expressed regarding accuracy. CMS believes base rates are an essential component of allowing consumers to compare affordable options. While we acknowledge that some consumers may be confused by the distinction between base rate and premium, we believe that HealthCare.gov does a better job of delineating the difference for consumers than do commercial sites, and we consider educating consumers about this difference to be one of the functions of the site.

Two commenters ask that we only collect information immediately displayed to the public through the HealthCare.gov web site, but note exceptions used for underlying determinations. This is exactly the current approach utilized by the HealthCare.gov plan finder team. As noted, CMS is reviewing data definitions, and will provide additional guidance regarding those few elements on the current templates which are duplicative, not used, or not planned for use. We note that the vast majority of elements not displayed are either used for processing of displayed elements, data structuring and evaluation, are planned for future display, or some subset of these three. Enrollment is incorporated into sorting and is used in evaluating compliance and coverage of the website. While no underwriting rating factors are collected, the set of eligibility and rating questions are designed into the current base rate calculation algorithms. Raw numbers of uprated offers and denials are used for displayed metrics. Plans are in place for a company level display of information, and additional eligibility and out of network costs are being scheduled for inclusion.