Appendix E - Benefits and Pricing

September 3 Data Requirement: Benefits and Pricing

As Section 1103(b)(2) makes clear, the ability of consumers to decide on affordable health care options requires additional information on benefits and cost sharing associated with a product. Specifically, the Secretary requires information on the "percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options."

To ensure accurate information, consistent presentation, and to minimize the burden on issuers, collection of this data was delayed until after the May 21 collection. As of September 3, 2010, however, issuers are required to provide information on the portal plan level as specified below.

Company Profile and Contact Information

A. Issuer Name: Issuer name shall be provided as the legal name of the entity registered to provide the plan within the coverage area.
B. IRS Federal Employer Identification Number (EIN): Issuers are required to provide the employer identification number under which they pay taxes to the IRS. This element is obtained solely to allow for unique identification of the entities, and required verification of information.
C. NAIC Company Code Number: Issuers are required to provide the NAIC Company Code number if they have one.
D. State: State in which plan coverage is offered.
E. Market type: In order to appropriately direct consumers, issuers will indicate whether the product specified is an individual or small group offering.
F. NAIC Group Code: If a company has an NAIC Group code, we ask that this be provided for administrative tracking.
G. Company Overview - A brief description of the company appropriate for consumers will be provided. This may also include separate data components for year of founding, the number of employees, subsidiaries and affiliates, corporate awards, logo, description of the coverage area, membership and the provider network.
H. Company address - The mailing address for the corporation.
I. Company URL - Universal resource locator for the company website.
J. Customer Service Phone number and TTY phone - For corporate contact.
K. Customer service email: For reaching corporate customer service.
L. Grievance and appeals contact: Issuers will submit the phone number and or URL for customers to contact them with grievances or appeals.
M. Data Submission Contact and backup (Phone Number & E-mail Address): Essential for reaching primary person responsible for the initial data entry.
N. Data Validation Contact and backup (Phone Number & E-mail Address): Person who will review and approve the submitted information on the web site before it goes live.
O. Rating: The issuer should report whether or not they have been rated by an independent company, the source of that rating, and what the rating is.
P. Plan enrollment: Number of covered lives for the most recent completed fiscal quarter.

Q. System for Electronic and Rate Form Filing (SERFF) number –The SERFF number by which many states accept applications for product level form filings will be added to plan level records.

Medical Benefits Information

A. Deductible: The specified dollar amount for which consumers are responsible for health care costs before the health insurance plan begins to pay for health care services. If a deductible applies to the plan we will require that this information be provided. Distinction will be made between in-network and out-of-network deductibles. Categories of deductibles will be collected to identify how a given plan distributes it's cost sharing.
B. Coinsurance: We will require a brief description of when co-insurance is applied, and what percentage is covered.
C. Out of Pocket Limit: This is defined as an annual cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost. Exclusions will be identified.
D. Primary Care Physician Required: This factor has significant effects on the relationship between a patient and their doctor, and as such is of importance to consumers, thus the Secretary will require it be reported.
E. Specialist Referrals Required: issuers will need to indicate to consumers whether a referral from their primary care physician is needed before seeing a specialist.
F. HSA Eligibility: Health Savings Accounts HSAs are one avenue used by many consumers to manage overall health care expenses. We will ask whether HSAs are supported under the plan.
G. Office Visits: The specified dollar amount, co-pay or coinsurance percentage associated with specific types of office visits. Types of visits will include: primary care physician office visit, specialist visits, periodic health exams, OB-GYN exam visits, and well baby care.
H. Prescription drug benefits: Insurance plans can treat prescription drug coverage differently, greatly affecting the costs for particular consumers. We will require issuers to provide the main dimensions of their drug coverage to ascertain co-pays, co-insurance and deductible for formulary drugs, brand name drugs, and generic drugs obtained from pharmacies or through mail order.
I. Additional Coverage: Other factors which are critical for individuals choosing insurance will be covered with specific questions regarding Lab/X-Ray work, Emergency Room visits, Outpatient Surgery, Hospitalization, Pre & Postnatal office visits, and Labor & Delivery Hospital Stays. We will require brief descriptions of the coverage of these items.
J. Dental Benefits: A description of dental benefits will be required, including whether there is a separate plan into which one is automatically enrolled, annual deductibles and maximums, coverage of general preventative procedures as well as more expensive options such as dental surgery and orthodontics.
K. Out-of-Network Coverage: A yes or no field regarding whether out of network care is covered combined with brief descriptions of the plan on this aspect will be required (including deductible, coinsurance, out-of-pocket-limit, and pre-authorization requirements).
L. Out-of-Country Coverage: A yes/no or short description of whether care obtained outside the country is covered under the plan. This information may be of critical importance to consumers who travel internationally.
M. Medical Records coverage: Are the costs of obtaining medical records covered under the plan.
N. Self directed account: (Small Group Only) A Self Directed Account is a health insurance plan that provides an annual dollar credit that can be used to pay for covered services. Any unused portion of the dollar credit may be carried over and added to the next year's credit if continuously enrolled in the plan. This information will be collected for small group plans.

O. Family Calculations (Individual Only): Some plans have separate family deductibles, out of pocket expenses, and/or maximums for coverage. The Secretary will ascertain whether these conditions exist and how they relate to the quoted personal amounts.
P. Chiropractic Services: Coverage of chiropractic services will be requested and include whether services are covered and how charges relate to the deductible, percent co-pay or co-insurance, number of visits per year, and maximum benefit amount.
Q. Mental Health Services: Coverage of mental health services will be required and include whether services are covered and how charges relate to the deductible, percent co-pay or co-insurance, number of visits per year, number of maximum inpatient stays, and maximum benefit amount.
R. Substance Abuse Treatment Coverage: Coverage of substance abuse treatment will be required and include whether services are covered and how charges relate to the deductible, percent co-pay or co-insurance, number of visits per year, number of maximum inpatient stays, and maximum benefit amount.
S. Annual Limit: The annual limits imposed on payments from an insurer for coverage will be identified both for in-network and out of network coverage.
T. Exclusions: Identified medical coverage and procedures which are excluded from service will be identified .

Eligibility and Rating Information, Individual Market

Various factors go in to the calculation of an individual consumer's out-of-pocket expenses for an insurance package. Currently, many states allow for medical under-writing which can affect a person's actual premiums through such issues as life-style choices and pre-existing medical conditions. To accurately reflect these issues, it will be imperative to gather information about how the issuer determines insurance rates.

The secretary will explore the best way to reflect these myriad differences in pricing schemes to provide the best estimate of costs possible. The data requirement will cover:

A. US citizenship. Is US citizenship required for plan membership.
B. Domestic Partnerships: Can domestic partners be covered under this plan. Does this include same sex domestic partners.
C. State citizenship: Under some plans, an applicant must have resided within the state for a certain period of time before coverage will be extended. We will require those limits be identified.
D. Other eligibility requirements: In cases where other non-health related questions are used to determine eligibility, the secretary will require that these be specified.
E. Age limits: Some plans have a maximum or minimum age for either primary applicants or for dependents. In cases where this is true, we will those limits will be noted.
F. Effective Dates: Given enrollment periods may sometimes differ, as can the time period during which rates are in effect. issuers will be required to identify the appropriate dates.
G. How often do rate updates typically occur?
H. Other categories: issuers in different states may apply a variety of specific non-medical conditions for membership or for the application of different pricing schemes. Plans may be limited to non-smokers, available only to particular occupations, or be subject to any number of limits. Where such categorical determinations exist, the issuers will be required to identify them.
I. Administrative Fees: If monthly fees are required by the plan, we will require that they be specified for the consumer.
J. Issuer fee Conditions: If issuer fees are applied, issuers will be required to identify the conditions for their application and calculation.

K. Rate calculation: Individual rates may be calculated on a number of different dimensions even before medical underwriting or even if medical underwriting doesn't apply. Issuers will be required to provide information on how their rates are calculated. It is anticipated that most issuers will be able to provide this by use of a "rate table" providing a breakdown by variables such as gender, age, smoking status, and a few additional variables. In cases where such tables do not adequately describe rating by the issuer, the issuer will provide a programmatic description of their rating formula in a step by step formula. Where issuers maintain a verification source which allows for third party comparisons, this information will be provided to allow the Government to review results from whatever calculations are required on our part.
L. Additional administrative specifications: Some factors related to how data must be specified for purposes of filling out applications or other forms will be ascertained. In some cases, issuers may have specific requirements on how forms must be filled out (such as children and spouses should be listed in age order).
M. How the service area is defined: In response to concerns from issuers, we are incorporating the ability to identify service areas by zip code, by county, by a combination, or simply by state as appropriate.
N. Lifetime maximum: consumers need to be informed of the maximum benefit that issuers will cover.

Eligibility and Rating Information, Small Group Market

Pricing of small group market health insurance plans can be determined by a wide variety of factors. In order to capture the broadest range, the Secretary is requesting the following elements for rate calculations and estimates. These data elements may be supplemented by a company rate table which identifies the relevant cells for their specific plans with a pre-calculated rate for those cells.

A. US citizenship. Is US citizenship required for plan membership.
B. Domestic Partnerships: Can domestic partners be covered under this plan
C. State citizenship: Under some plans, an applicant must have resided within the state for a certain period of time before coverage will be extended. We will require those limits be identified.
D. Age limits: Some plans have a maximum or minimum age for either primary applicants or for dependents, and for small groups this may be effected by the size of the group. This information will be captured through a short series of questions.
E. Rating tier to be quoted: Some issuers will provide rate tables based on a tier structure applied across plans. In such cases, the tier for a plan must be identified.
F. Whether SIC or NAICS codes are used: An administrative field for identifying the types of employers who may be covered.
G. Is the service area/rate structure based on the employer or employee location: Rates may be quoted on the basis of the place of employment or where an employee lives. We muct ascertain this to provide accurate quotes.
H. Service area coverage: Must an employee live within the service area to be eligible?
I. Should out of state employees be given a rate or quoted $0?
J. Coverage area administrative specifications: To determine the appropriate path for rate estimation, questions will be asked regarding whether the determination of service areas is determined in the same way across plans and states.
K. Fees: Issuers will be required to identify whether there are application or administration fees which consumers should factor into their decision.

L. Age questions: Small group market insurance costs may be affected by the age of employees, and age cut offs. This effect may also vary by group size or student status or may be applied to dependents. Questions will be used to determine whether this is the case.
M. Specified rating factors: In some states ratings are allowed to very based on gender and/or the inclusion of children. If these factors have an effect on rates, we will ask issuers to identify them.
N. Other factors: If non-identified factors create a strata for plan pricing, we will ask to be informed of those factors.
O. Minimum participation/contribution requirements: A specification of the minimal percentage of employees or employee contributions who would be required to enroll.
P. Administrative calculation factors: While most data elements are being collected to display to consumers or fed directly into rate calculations, others may simply be important for determining the best approach to incorporate their data. These issues will be covered by a small set of questions such as the minimum time in business rules, whether rates are calculated on the basis of tables or through algorithms and a rating engine, and where verification data may be found if new algorithms must for required by issuers.
Q. Rate calculation specifications: In order to validate and develop ratings solutions, issuers will be asked to provide a step-by-step description of their ratings process.
R. How the service area is defined: In response to concerns from issuers, we are incorporating the ability to identify service areas by zip code, by county, by a combination, or simply by state as appropriate.