

## **Appendix C Insurance Issuer and Product Level Data**

### ***Issuer Requirements for Individual Market or Small Group Market***

This section covers requests for information from issuers with offerings of health insurance coverage on an individual or small group basis. The Patient Protection and Affordable Care Act (ACA), Section 1103(a)(2) “Connecting to Affordable Coverage” (as modified by section 10102) requires the Secretary to “provide ways for residents of, and small businesses in, any state to receive information regarding their health insurance options, including “health insurance coverage offered by health insurance issuers” under sub-section (A).

As a result the Secretary is requiring that each issuer report on individual and small group health insurance plans, both the package of benefits and a specific cost sharing option for that product.

While some of the required information is already gathered by the states, most states do not require detailed specification of benefits and pricing necessary for informed consumer decisions. The variance between state collection standards also makes aggregating the data in a single place for comparisons impossible. As a result, the Secretary is requiring a new data submission.

As this information is already compiled by issuers, minimal difficulties are anticipated in meeting these reporting requirements. The primary burden will likely be transforming the data into a standardized reporting format. Nevertheless, the emergence of a standard for reporting will allow for commonalities to emerge which will reduce the burden of meeting current data requirements utilizing a variety of standards from the states and federal government.

The following criteria were used in selecting reporting requirements:

- 1) Utility for citizen discovery and differentiation of available health insurance options in their area of residence;
- 2) Minimal administrative burden on issuers;
- 3) Legislative and regulatory authority;
- 4) Rapid availability of valid, reliable data elements.

To reduce the ultimate burden on issuers, the Secretary first undertook to contract with a vendor with significant coverage of information in these two markets. An initial data collection from issuers and States was required to provide minimal information used to define the universe of plans in an area. This data was also used to verify that all issuers are ultimately represented, and that information gathered is correct. This information was required by May 21, 2010 in order to define from whom additional information was needed. The elements collected from these issuers have been collected periodically for updates regarding corporate details as well as information on available products.

## **Subsequent Data Collection:**

### ***Issuer Corporate and Contact Information***

One requirement for connecting citizens to affordable coverage is the name of the issuers from whom they can purchase coverage and the contact information of those parties.

- 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. Marketing Name: The primary name under which issuers identify themselves for consumers. To the extent an issuer believes they have created a brand identity for communication with issuers that is useful to maintain, we ask that they include these marketing names.
- C. 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.
- D. NAIC Company Code Number: Issuers are required to provide the NAIC Company Code number if they have one.
- E. NAIC Group Code: If a company has an NAIC Group code, we ask that this be provided for administrative tracking.
- F. Issuer Address: The Issuer Address is the official street address used to receive information requests from the public via the US Postal Service or commercial postal firms.
- G. Rating: The issuer can report whether or not they have been rated by one or more independent companies, the source of those ratings, and the actual most recent ratings. This is an optional field which may be incorporated into issuer level reporting at a later time.
- H. Customer Service Phone Number – Toll-Free: This element should be provided if a toll free number is available for specific consumer requests for plan information.
- I. Customer Service Phone Number – Local: This element represents a local phone number within the area of coverage retained by the issuer for receiving requests for information from the public.
- J. Customer Service Phone Number – TTY: This element represents a phone number for receiving information from the deaf.
- K. Customer service email: For reaching corporate customer service.
- L. Website address – link to Issuer: The universal resource locator of the issuer which contains general information on the company.
- M. Contact Information – Up to three contact names, phone numbers and email addresses will be collected for primary and backup contacts for individual and small group markets allowing for different information to be entered for data submission and data validation contacts.
  - a. Data Submission Contact and backup (Phone Number & E-mail Address): Essential for reaching primary person responsible for the initial data entry.
  - b. Data Validation Contact and backup (Phone Number & E-mail Address): Person who will review and approve the submitted information on the website before it goes live.
  - c. Authorized Data Attestation Officials: Two factor authentication will require that basic contact information will need to be collected.
- N. Grievance and appeals contact: Issuers will submit the phone number and or URL for customers to contact them with grievances or appeals.
- O. State: The state of the product offering. Given that health insurance regulation is managed primarily at the state level, issuers will be recorded at the state level within the database.

### ***Product administrative information***

While future implementations of Section 1103 of the ACA may ask for additional administrative information necessary for consumers to be able to evaluate plans, in order to minimize the burden on issuers we will not focus on those details for this data request. Other elements that will not be covered in this request are to be collected under 2718 of the PHSA (specifically the medical loss ratio in 2011), but are not being

requested at this time. We do require enrollment. Our intent at this time is to gather a minimum amount of information necessary to prioritize the presentation of information and coordinate plan and product level data.

- A. Product enrollment: Number of individual (or family) enrollments for the most recent completed product year.
- B. Number of applications received: The number of applications which were submitted for enrollment under the product during the reference quarter according to the schedule specified below.
- C. Number of administrative denials: Some individuals apply for insurance products which they do not qualify for due to membership limitations, applying outside of open enrollment, etc. These types of denials will be tracked separately to make sure insurers are not penalized in the calculation of denial percentages.
- D. Number applications denied for product enrollment (individual market only): In order to inform consumers about the relative risk that they will be unable to obtain this insurance, issuers will report the number of applications which were denied for enrollment or pended for healthcare intervention (for example until after surgery) or not accepted at terms applied for but offered a counteroffer (for example offered a policy under a much higher deductible, or with a rider that limits coverage for a condition or body part) during the reference quarter.
- E. Number up-rated offers: Actual premiums may vary widely for most products. Issuers are required to report the number of offers issued for a product which were "up-rated," such that the underwriting process has resulted in a premium quote higher than the base rate for the reference quarter.

Reference Quarters for Reporting on Applications refer to the actions occurred during prior quarter, and issuers will be required to report the most recent prior quarter starting in the third month of the current quarter. Enrollment will be collected as of the last day of the prior quarter starting in the third month of the current quarter.

- F. Product Status: Indicates the current offering status of the product as regards to its inclusion on the website. Statuses include withdrawn from market, pending approval by the state, approved but not open to new enrollees, active but only during an annual enrollment period, and may identify other types based on additional issuer feedback.
- G. Special Product Categories: Additional types of insurance product statuses will be collected to allow for proper rate review and other reporting. These include association product status and whether a product has been grandfathered.
- H. Standard Policy Period: The time period for which a policy is issued (e.g., six months, one year, two years, other). Where an issuer chooses "other," a free-text field will capture the appropriate answer. This will be a required field, as all plans have a policy period.
- I. Required Renewal Date: Yes or No field intended to capture information on plans that have a policy year beginning on a consistent specified date (normally the first day of a particular month) other than the standard policy period. If yes, the date will be reported.
- J. Open enrollment: Some products are limited to a specified period during which individuals may enroll. Issuers will be required to identify if that is the case for a particular product, to identify the actual period by start and end day within the year, and will indicate whether they wish the product to be referenced on the site outside of that enrollment period.
- K. 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 product level records.

### ***Product contact and detail information***

This section references the specific fields necessary to identify the product, and for consumers to obtain specific plan level information.

- A. Product name: The legal name under which the product is marketed to consumers. It should be substantively similar to product name reported in Part II Section 1(a) of IRS Form 5500.
- B. Product number: In cases where a product has an assigned three digit product number equivalent to the product number/Enrollment Code used for filing IRS Form 5500, that information shall be provided.
- C. Market type: In order to appropriately direct consumers, issuers will indicate whether the product specified is an individual or small group offering.
- D. Product type (e.g., indemnity/HMO/PPO): Product type is the most common means of identifying general limits on provision of services. To provide the consumer with a basic understanding of the plan, it is essential to gather the type of product. These types will be defined in correspondence with the "health care plans and systems" defined by the Interdepartmental Committee on Employment-based Health Insurance Surveys (Indemnity Plan, HMO, PPO, etc.).
- E. Website address –brochure: If available, the URL link to the specific product brochure from the issuer.
- F. Website address –Formulary: If available, a URL link to a list of prescription drugs, both generic and brand name that are available through the health product.
- G. System for Electronic and Rate Form Filing (SERFF) number – At the request of states, the SERFF number by which many states accept applications for product level form filings will be added to product records for update starting in September 2010. This unique identifier will be extremely helpful for tracking and matching product level data to plan information and administrative records.

### ***Provider network information***

Insurance products are generally characterized by three different types of health care provider arrangements: exclusive providers, any providers, and mixed where particular incentives are offered for using certain providers. These mixed and exclusive arrangements are generally identified as "provider networks." In pertinent cases, we require that a link to that information on the web be provided. This is a necessary requirement to inform consumers as to the ability of a product to pay within their existing health care relationships, and is essential information on how to obtain an appropriate physician once a plan has been chosen.

- A. Provider Network: Issuers will be asked to indicate whether the product utilizes a specific network of providers.
- B. Website address – Provider Network: If available, a URL link to a listing of exclusive or preferred care providers.