

CMS Responses to Comments Received Regarding OMB Control Number 0938-1086; Data Collection for HealthCare.gov Planfinder

As of this writing, there are several data fields for data collection to begin in a few weeks that are currently unavailable or yet undefined through technical guidance or instructions. **Technical Documentation and finalized versions of the templates have been provided for the small group data collection. The majority of new fields were derived directly from the Summary of Benefits and Coverage available on the NAIC site with a final version posted in July.**

CMS is requesting information on whether the benefit is covered, not covered, available for an additional premium or covered with limitations but these terms are undefined. **Terms and categories were developed in discussions with AHIP and BCBSA, and reflected suggestions received from issuers. Definitions were posted to CCIIO website September 26.**

CMS has not released revised templates for health plan review for the Health Insurance Oversight System (“HIOS”) which are the templates used to provide summary level information for the individual and small group market. The materials associated with the PRA submission indicate that several fields are added (e.g., standard policy period, required renewal date and open enrollment) but no additional guidance has been provided. **These fields were included due to some issuer comments that the current data collection does not adequately represent products which have specified periods for enrollment. The concepts are well understood within the industry, and the collection adds minimal additional effort. Training has been provided on September 23rd, and additional guidance will be provided as needed.**

Using the same data collection system for the Plan Finder and the rate review processes has posed challenges. We understand that to accommodate the rate review requirements new fields are being added to the data templates regarding association health plans. We recommend that CMS release information as soon as possible given health plans are required to submit this information beginning on November first. We note that some of the proposed data fields may be burdensome to collect given that health plans may not have information about the fees that associations charge their members. **Concern has largely been due to misunderstandings deriving from rate review process. No new requirements have derived from the collection associated with HealthCare.gov. Rate review collection covers some products which were not required to report to HealthCare.gov previously.**

Recommendation: CCIIO should immediately release definitions and technical instructions for the planned data fields related to the small group insurance market and association plans. If these materials are not available soon, we recommend that the planned data collection be delayed. **Field definitions have been released together with finalized templates September 26. Definitional constraints are minimal as had been communicated, as to be consistent with the definitions derived with the NAIC and available since July.**

Small Group Templates

CMS is dedicated to minimizing the burden associated with the full data collection requirements associated with the ACA. Section 1103 provides CMS with authority to collect benefits information sufficient to inform consumers as to their available affordable health care insurance options. The initial collection instrument was designed toward this end, but did not have a standardized data reporting model to apply. Moving forward, we have determined that it will significantly reduce issuer burden if we collect this information consistent with the standard proposed for the Summary of Benefits and Coverage developed in coordination with the NAIC.

While we recognize that some elements of this standard may not be the most convenient for all issuers, utilizing the standard allows for system consistencies by issuers. Additionally, CMS has suggested that data reporting requirements under the emerging MPRM covering section 2715 of the ACA can be minimized if the format of the SBC is utilized for HealthCare.gov. We intend that issuers who provide that information to HealthCare.gov would be able to reference the site rather than generating individually constructed reports for consumers before application. To the extent that the standard for the Summary of Benefits and Coverage change and may become

simplified over time, CMS will consider removing or revising those fields.

Copay Out of Network –Without specific technical requirements or definitions, it is unclear what this proposed field is intended to represent given that as a standard practice health plans do not have copays out of network. We recommend deleting this field. **This field was included to be consistent with the standard SBC format proposed by the NAIC. This is a simple concept regarding the copay for primary care physician. Definition available on cciio.cms.gov**

Coinsurance In Network and Coinsurance Out of Network – We recommend clarifying whether this data field refers to “Member Coinsurance” or “Plan Coinsurance.” **Definitions were provided in guidance posted September 26th.**

Other Practitioner office visit –We recommend deleting this field. **This field was included to be consistent with the standard SBC format recommended by the NAIC. The concept is intended to be simple, and regards the copay for other health practitioners which can be derived from a review of plan brochures. The Definition available on cciio.cms.gov**

Diagnostic test (x-ray, blood work) – We recommend revising this field to read “Diagnostic test (xray and lab work).” **Adopted**

Non-Preferred Brand drugs – We recommend revising this field to read “Non-preferred brand and generic drugs.” **Adopted**

Specialty drugs (e.g. chemotherapy) – We recommend deleting the “e.g. chemotherapy” as this is not always a specialty drug. **Adopted**

Outpatient Facility etc. – We recommend revising this field to read “Outpatient Facility Services.” **Adopted**

Outpatient Physician etc. – We recommend revising this field to read “Outpatient Physician and Surgical Services.” **Adopted**

Emergency medical etc. – We recommend this field is revised to read” Emergency transportation/ambulance.” **Adopted**

Urgent Care – We recommend revising this field to read “Urgent Care Centers or Facilities.” **The question as derived from the SBC actually refers to the broader category of urgent care, rather than specific applications to Urgent Care Facilities. Guidance is provided in the materials posted September 26th.**

Hospitalization facility fee etc. – We recommend revising this field to read “Inpatient Hospital Services.” **Adopted**

Hospitalization Physician etc. – We recommend revising this field to read “Inpatient Physician and Surgical Services.” **Adopted**

Delivery etc. – We recommend revising this field to read “Hospital Services for Delivery (Maternity).” **Adopted**

Home Health – We recommend revising this field to read “Home Health Care Services” **Adopted**

Rehabilitation Services – We recommend renaming this field to read “Outpatient Rehabilitation Services.” **Adopted**

Habilitation Services – We recommend deleting this field as this is not a commonly provided benefit and it is unclear as to what is included in this category. **This field was included to be consistent with the standard SBC format recommended by the NAIC. Guidance has been provided on cciio.cms.gov.**

Skilled Nursing Care – We recommend revising this field to read “Skilled Nursing Facility.” **Adopted**

Eye Exam – We recommend changing this field to “Routine Eye Exams.” **Adopted with modifier (children)**

Glasses – We recommend revising this field to “Eye Glasses.” **Adopted**

Dental Care (Adults) – We recommend deleting or revising this field to read “Routine Dental Services.” **This field was included to be consistent with the standard SBC format recommended by the NAIC, but renamed as suggested.**

Long Term Care – We recommend revising this field to read “Long term/custodial nursing home care.” **Adopted**

Private Duty Nursing – We recommend deleting this field. **This field was included to be consistent with the standard SBC format recommended by the NAIC. Guidance has been provided on cciio.cms.gov.**

Routine Eye Care (Adult) – We recommend deleting this field as eye exams are already mentioned above. **This field was included to be consistent with the standard SBC format recommended by the NAIC. The form distinguishes between children and adults. Guidance has been provided on cciio.cms.gov.**

Routine Foot Care – We recommend revising this field to read “Routine Foot Care for Diabetics.” **This field was included to be consistent with the standard SBC format recommended by the NAIC. Almost all plans cover required care associated with diseases which affect blood flow to the extremities. This field covers actual foot care not associated with such maladies.**

Weight Loss Programs – We recommend deleting this field as it is not a benefit category but offered as a discount wellness program. **This field was included to be consistent with the standard SBC format recommended by the NAIC, additional guidance was provided in the materials posted September 26th. Issuers may submit the information relating to benefits such as discounts to membership costs.**

Small Group Business Rules Template – We recommend that this template is deleted. The minimum and maximum number of eligible number of employees to qualify for small group insurance products is defined through state law, thus there is no need for all health plans to complete a spreadsheet with this information for each of their products that is open to enrollment. **Accepted**

Service Area Details for Small Group and Product Availability Templates – These templates collect information on where each small group product is available. We note that the reporting templates for the Health Insurance Oversight System (HIOS) collect some duplicate information. However, at this writing the updated templates for HIOS are not available so we are unable to comment on whether there are duplicate data elements collected through two separate systems. **Data is being pre-populated from the HIOS system. The new template allows issuers to report using additional categories (counties instead of only zip and state) which will make future collections easier. Additionally, the new system allows issuers to save service areas and assign them rather than entering a full set of zip codes for each product submitted.**

Premium and Enrollment Concerns

The submission of written premium dollar figures is competitively sensitive information and is not currently available in the public domain. We highlight the importance of protecting this confidential and competitively sensitive information and recommend that CMS put in place additional protections to these data. **Agreed. CMS has coordinated capturing information regarding confidential business designations through the 12600 process, and has done a careful review of rating factors and other information available on a state by state basis.**

We recommend that the Plan Finder include a description of what the “Monthly Premium Estimate” means. An accurate definition is necessary to provide clarification on what the estimate means and will ensure the data is used appropriately. It is critical that employers know that their employee’s actual premiums if enrolled could be higher or lower than this stated amount depending on the number of persons for whom coverage is offered and what

underwriting factors, if, any, will be applied to calculate their final monthly premium costs. We also recommend the disclaimer note the dollar figure is for general comparative purposes only. The term “Monthly Premium Estimate” will not be used on the web site—the cost estimate will be referred to as an “Estimated Average Cost Per Enrollee.” The “Estimated Average Cost Per Enrollee” will be derived from two data points reported by the issuer. The number will be calculated as one third the total written premium covering the reference quarter (April 1 to June 30) divided by the enrollment as of June 30. This takes into account that premium is collected over a period of three months while enrollment is collected at a single point in time. The disclaimer which will accompany it will read: “The actual cost per month may be significantly higher or lower than the average costs shown here, based on an employee’s choice of deductible and cost sharing options as well as other factors.” We will be creating minimum cut off levels based on either enrollment or collected premium amounts. Products whose enrollment is below a certain number or whose premium amounts are below a certain number will be displayed with the “estimate is unavailable” message.

Recommendation: We request that CCIIO immediately release the exact final methodology and the applicable time period for the collection of enrollment data and premiums that will be the basis for the calculation of the displayed monthly premium amount and ensure the confidentiality of these data will be ensured. Agreed. This information has been disseminated in meeting with industry groups as well as on our weekly calls with issuers. The information has been sent subsequently via memo, and is available on the CCIIO website. The time periods are consistent with those which have been used for the prior data collections. Confidentiality of the information will be determined through the process associated with Executive Order 12600. Issuers will be provided with the opportunity to comment on the confidential nature of all new data elements, and a thorough review is conducted by CMS prior to any future data release. We believe the associated process will adequately address the concerns of industry to protect their confidential information.