Revisions Crosswalk (CMS-10320): OMB 0938-1086
Changes Made Prior to 60 Day Posting. (Cumulative Changes Current as of 08/04/2011)

(all pages refer to new)

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
1.	All	All	Change "OCIIO" to "CCIIO"	See change in *Actions to be Performed* column	Change in Name of organization
2.	A1	App A, Sect A	Edit	Replace "This is an emergency request for a six month period until additional details are determined and a more comprehensive system is developed." With "This collection was initially approved under OMB control number 0938-1086. This draft is being provided for the 60 day period for comment by the public."	Different Action
3.	A1-2	AppA, Sect A(3)	Edit	Replace "The states will be tasked to provide information on issuers in their state and various websites **(see Appendix C)**. The issuers will ultimately be given the choice to download a basic information template to enter data then upload into the portal, or manually enter data within the portal itself. Information to be collected can be found in **Appendix D**. … The pricing and benefits data that will be collected can be found in Appendix E." with "The states were asked to provide information on issuers in their state and various websites **(see Appendix E)**. … Information to be collected on issuers and products can be found in **Appendix C**. **The pricing and benefits data that will be collected can be found in Appendix D. The templates and**	Clarifications based on re-numbering of Appendices

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				instructions presented in support of this PRA package as Appendix G are those developed for the prior data collections."	
4.	A1-2	AppA, Sect A(3)	Edit	Replace "Once the states and issuers submit their data, they will receive an email notifying them of any errors, and that their submission was received. The issuer's data will be sent to the IT Vendor who will be responsible for collecting the benefits, cost sharing, and premium rate information from the issuers." with "The issuers have been downloading a basic information template to enter data then upload into the portal."	Process has changed, original text may not be accurate moving forward.
5.	A2	Sect. A(4)	Addition	In anticipation of implementation of the A.C.A. section 2715 requirement for specific standards of reporting information to consumers, we have attempted to align our data collection with the structure for a Summary of Benefits and Coverage as recommended by the National Association of Insurance Commissioners (NAIC). The specifics are delineated in Appendix D.	Clarifies relationship to Summary of Benefits and Coverage currently under consideration.
6.	A2	Sect. A(6)	Edit	Replace "OCIIO is mandating the issuers and is requesting the states to verify their information on an annual basis. In the event that an issuer enhances their existing plans, proposes new plans, or deactivates plans, the organization would be required to update the information in the web portal using the edit function or uploading an updated template." With "CCIIO has been operating with an approximately 45 day refresh schedule to obtain changes in plan benefits	Clarifies the decrease in the collection time periods to reduce burden

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				and pricing as well as comprehensive lists of products approved within a state for sale to the public. In the event that an issuer enhances their existing plans, proposes new plans, or deactivates plans, the organization would be required to update the information in the web portal using the edit function or uploading an updated template within an open window period. In response to the desire to decrease burden as much as possible, it is anticipated that we will adjust our collection period to quarterly. Through the use of effective dates and periodic windows of opportunity for changes, we anticipate that we can decrease the overall burden for the data collection significantly."	
7.	Old 2	Sect. A(6)	Deletion	If this collection were not conducted or were conducted less frequently than described above, there would be adverse consequences, including but not limited to, the following: • OCIIO would not be able to accurately or effectively educate the public on the private plan choices available to them. • OCIIO would not be able to effectively provide this information as required by statute. • The public would not receive accurate, updated plan information via the website.	No longer pertinent based on changes to schedule
8.	A2	Sect. A(7)	Edit	Replace "Therefore there will be no burden on these entities within the first year of this collection." With "Administrators have been voluntarily entering changes as they develop, so no general call for the	Time reference is no longer pertinent

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				collection of data from these groups is currently contemplated.“	
9.	A3	Sect. A(8)	Edit	Replace “Certain feedback tools have been built into the healthcare.gov site to allow for consumer and other input on how the data is being presented. OCIIO also plans to ultimately collect feedback from the public to help drive future enhancements to the web portal that will allow more beneficial information to be displayed.” With “Weekly calls have been held during collection periods to get feedback from those responsible for submitting data. These calls have averaged over 100 industry representatives, and have led to a number of clarifications and enhancements.”	While some web tools exist, the weekly phone calls have been a far more influential source of information.
10.		12		BURDEN ESTIMATE	
11.		14		COSTS TO FEDERAL GOVERNMENT	
12.		15		CHANGES TO BURDEN	
13.	C1	App C, Sec A	Edit	“As a result the Secretary is requiring that each issuer report on individual and small group health insurance plans, *coverage options that combines both the product (package of benefits) and a specific cost sharing option for that product*” **BECOMES** “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*.”	Edit for clarity
14.	C1	App C, Sec A	Deletion	“known to and” was deleted from the statement, “As this information is already ~~known to and~~ compiled by the issuers, minimal difficulties are anticipated in meeting these reporting requirements.”	Edit for clarity

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
15.	C1	App C, Sec A	Edit	"To reduce the ultimate burden on issuers, the Secretary *will undertake* to contract with a vendor who currently has significant coverage of information in these two markets." **BECOMES** "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.	Change due to timing of releases
16.	C1	App C, Sec A	Edit	"Initial data requirements will thus take place in two stages. First, issuers and States will be required to provide minimal information used to define the universe of plans in an area. This data will also be used to verify that all issuers are ultimately represented, and that information gathered is correct. This information will be required by May 21, 2010 in order to define from whom additional information is required." **BECOMES** "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."	Change in process due to timing

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
17.	C2	App C, Sec B	Addition	Added "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," as item B	Moved from benefits appendix
18.	C2	App C, Sec B	Addition	Added "NAIC Group Code: If a company has an NAIC Group code, we ask that this be provided for administrative tracking," as item E.	Moved from benefits appendix
19.	C2	App C, Sec B	Addition	Added "Customer service email: For reaching corporate customer service," as item K.	Moved from benefits appendix
20.	C2	App C, Sec B	Edit	Item L, "Website address – link to Issuer: The URL of the issuer which contains general information on the company." **BECOMES** "Website address – link to Issuer: The universal resource locator of the issuer which contains general information on the company."	Edit for clarity
21.	C2	App C, Sec B	Edit	Item G, "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." **BECOMES** "Rating: The issuer should 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."	Edit to address plural of ratings. Response to issuers.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
22.	C2	App C, Sec B	Addition	Added: 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. As sub items under "M – Contact Information"	Moved from benefits appendix
23.	C2	App C, Sec B	Addition	Added "Company Overview - A brief description of the company appropriate for consumers will be provided. This may include separate data components for year of founding, the number of employees, subsidiaries and affiliates, corporate awards, description of the coverage area, membership and the provider network" as item N.	Moved from benefits appendix
24.	C2	App C, Sec B	Addition	Added "Grievance and appeals contact: Issuers will submit the phone number and or URL for customers to contact them with grievances or appeals" as item O.	Moved from benefits appendix
25.	C2	App C, Sec B	Addition	Added "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," as item P.	Moved from benefits appendix
26.	C2	App C, Sec B	Deletion	Deleted section entitled "Geographic coverage information and its subsequent points – state and offering area. "State" was moved up to the Issuer Corporate and Contact Information section as item P.	Edit for clarity
27.	C2	App C, Sec C	Edit	"Information providers" was changed to "issuers" in the introductory paragraph under "Product administrative information."	Edit for consistency

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
28.	C3	App C, Sec C	Edit	Item C, "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) during the reference quarter." **BECOMES** "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"	Edit for consistency with guidance.
29.	C3	App C, Sec C	Edit	Specific reference quarters (e.g., September data collection) were removed and replaced with, "*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."*	Edit to clarify change in process to enhance timeliness of the data.
30.	C3	App C, Sec C	Addition	"Product Status: Indicates the current offering status of	Change to process based on

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				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. Additional types of insurance product statuses will also be included, such as association product status and whether a product has been grandfathered," was added as item E.	feedback from issuers as to the status of their offerings.
31.	C3	App C, Sec C	Addition	"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," was added as item F.	Added element based on feedback from consumer advocates.
32.	C3	App C, Sec C	Addition	"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," was added as item G.	Added element based on feedback from consumer advocates.
33.	C3	App C, Sec C	Addition	"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," was added as item H.	Added element based on feedback from issuers.
34.	C3	App C, Sec C	Addition	"System for Electronic and Rate Form Filing (SERFF) number –The SERFF number by which many states	Moved from benefits appendix

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				accept applications for product level form filings will be added to product level records," was added as item I.	
35.	C4	App C, Sec D	Addition	"Provider Network: Issuers will be asked to indicate whether the product utilizes a specific network of providers," was added as item A.	Moved from benefits appendix
36.	D1	App D, September 3 Data Requirement: Benefits and Pricing	Appendix E in the former PRA is now Appendix D in the New PRA	Appendix E in the former PRA is now Appendix D in the New PRA.	Improved Organization
37.	D1	App D, September 3 Data Requirement: Benefits and Pricing	Deletion	Replace "As of September 3, 2010, however, issuers will be required to provide information on the portal plan **level as specified below**." with "As of September 3, 2010, however, issuers will be required to provide information on the portal plan **level. Details of the portal plan collection are specified below.**"	Edit for clarification.
38.	D1	App D, Portal Plan General Information	Addition	A. Portal Plan name: The name under which a particular portal plan should be listed on Healthcare.gov for display to consumers. B. Portal Plan enrollment: Number of covered lives for the most recent completed fiscal quarter.	Definition of Portal Plan and Portal Plan enrollment.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
39.	D1	App D, Medical Benefits Information	Addition	"In order to minimize the burden on issuers of reporting similar information in different formats as well as to maximize the involvement of all players in the data display decisions, the decision was made to utilize the "Summary of Costs and Coverage" (SCC) developed by the insurance industry and regulators through the National Association of Insurance Commissioners (NAIC). The following items will be collected in the format consistent with the SCC included among the supporting materials."	Describes the background of the Summary of Costs and Coverage (SCC) created by the NAIC.
40.	D1	App D, Medical Benefits Information	Addition	A. Primary care visit to treat an injury or illness: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for visiting a primary care physician to treat an injury or illness.	New Item in the Summary of Cost and Coverage (SCC).
41.	D1	App D, Medical Benefits Information	Addition	B. Specialist Visit: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for visiting a Specialist.	New Item in the Summary of Cost and Coverage (SCC).
42.	D1	App D, Medical Benefits Information	Addition	C. Other practitioner office visit: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for visiting other practitioners for an office visit.	New Item in the Summary of Cost and Coverage (SCC).
43.	D1	App D, Medical	Addition	D. Preventive care/screening/immunization: The issuer will report either the copay as a fixed dollar	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Benefits Information		amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions to preventive care, screenings, and immunizations.	
44.	D1	App D, Medical Benefits Information	Addition	E. Diagnostic tests and Lab Work: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs in three separate categories – doctor's offices, standalone centers, and hospitals. Additionally, issuers will report limitations and exceptions for diagnostic tests (lab work and blood work).	New Item in the Summary of Cost and Coverage (SCC).
45.	D2	App D, Medical Benefits Information	Addition	F. Imaging (CT/PET scans, MRIs): The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs in three separate categories – doctor's offices, standalone centers, and hospitals. Additionally, issuers will report limitations and exceptions for imaging (including CT/PET scans and MRIs).	New Item in the Summary of Cost and Coverage (SCC).
46.	D2	App D, Medical Benefits Information	Addition	G. Advanced Imaging: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs in three separate categories – doctor's offices, standalone centers, and hospitals. Additionally, issuers will report limitations and exceptions.	New Item in the Summary of Cost and Coverage (SCC).
47.	D2	App D, Medical Benefits Information	Addition	H. X-rays: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs in three separate categories – doctor's offices, standalone centers, and hospitals.	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				Additionally, issuers will report limitations and exceptions.	
48.	D2	App D, Medical Benefits Information	Addition	I. Generic Drugs: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider, out of network provider costs, and mail order costs. Additionally, issuers will report limitations and exceptions for the purchase of generic drugs.	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
49.	D2	App D, Medical Benefits Information	Addition	J. Preferred brand drugs: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider, out of network provider costs, and mail order costs. Additionally, issuers will report limitations and exceptions for the purchase of preferred brand drugs.	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
50.	D2	App D, Medical Benefits Information	Addition	K. Non-preferred brand drugs: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider, out of network provider costs, and mail order costs. Additionally, issuers will report limitations and exceptions for the purchase of non-preferred brand drugs.	New Item in the Summary of Cost and Coverage (SCC).
51.	D2	App D, Medical Benefits Information	Addition	L. Specialty drugs (e.g., chemotherapy): The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider, out of network provider costs, and mail order costs. Additionally, issuers will report limitations and exceptions for the purchase of specialty drugs (such as chemotherapy).	New Item in the Summary of Cost and Coverage (SCC).
52.	D2	App D, Medical Benefits Information	Addition	M. Outpatient Surgery Facility fee (e.g., ambulatory surgery center): The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions to the fees associated with outpatient facilities (such as ambulatory surgery centers).	New Item in the Summary of Cost and Coverage (SCC).
53.	D2	App D, Medical Benefits Information	Addition	N. Outpatient Surgery Physician/surgeon fees: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for physician and surgeon fees associated with outpatient surgery.	New Item in the Summary of Cost and Coverage (SCC).
54.	D2	App D, Medical Benefits Information	Addition	O. Emergency room services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				will report limitations and exceptions for emergency room services.	
55.	D2	App D, Medical Benefits Information	Addition	P. Emergency medical transportation: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for emergency medical transportation.	New Item in the Summary of Cost and Coverage (SCC).
56.	D2	App D, Medical Benefits Information	Addition	Q. Urgent care: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for urgent care.	New Item in the Summary of Cost and Coverage (SCC).
57.	D2	App D, Medical Benefits Information	Addition	R. Hospital Stay Facility fee (e.g., hospital room): The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations (e.g., number of days and number of admissions per year) and exceptions for hospital stay facility fees (such as a hospital room).	New Item in the Summary of Cost and Coverage (SCC).
58.	D2	App D, Medical Benefits Information	Addition	S. Hospital Stay Physician/surgeon fee: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for hospital stay physician and surgeon fees.	New Item in the Summary of Cost and Coverage (SCC).
59.	D3	App D, Medical Benefits Information	Addition	T. Mental/Behavioral health outpatient services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				and exceptions for mental and behavioral health outpatient services.	
60.	D3	App D, Medical Benefits Information	Addition	U. Mental/Behavioral health inpatient services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for mental and behavioral health inpatient services.	New Item in the Summary of Cost and Coverage (SCC).
61.	D3	App D, Medical Benefits Information	Addition	V. Substance use disorder outpatient services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for substance use disorder outpatient services.	New Item in the Summary of Cost and Coverage (SCC).
62.	D3	App D, Medical Benefits Information	Addition	W. Substance use disorder inpatient services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for substance use disorder inpatient services.	New Item in the Summary of Cost and Coverage (SCC).
63.	D3	App D, Medical Benefits Information	Addition	X. Prenatal and postnatal care: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for prenatal and postnatal care.	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
64.	D3	App D, Medical Benefits Information	Addition	Y. Delivery and all inpatient services for maternity care: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for the delivery and all inpatient services for maternity care.	New Item in the Summary of Cost and Coverage (SCC).
65.	D3	App D, Medical Benefits Information	Addition	Z. Home health care: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for home health care.	New Item in the Summary of Cost and Coverage (SCC).
66.	D3	App D, Medical Benefits Information	Addition	AA. Rehabilitation services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for rehabilitation services.	New Item in the Summary of Cost and Coverage (SCC).
67.	D3	App D, Medical Benefits Information	Addition	BB. Habilitation services: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for habilitation services.	New Item in the Summary of Cost and Coverage (SCC).
68.	D3	App D, Medical Benefits Information	Addition	CC. Skilled nursing care: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for skilled nursing care.	New Item in the Summary of Cost and Coverage (SCC).
69.	D3	App D, Medical	Addition	DD. Durable medical equipment: The issuer will report either the copay as a fixed dollar amount or	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Benefits Information		the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for durable medical equipment.	
70.	D3	App D, Medical Benefits Information	Addition	EE. Hospice service: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for hospice service.	New Item in the Summary of Cost and Coverage (SCC).
71.	D3	App D, Medical Benefits Information	Addition	FF. Eye exam for children: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs.	New Item in the Summary of Cost and Coverage (SCC).
72.	D3	App D, Medical Benefits Information	Addition	GG. Glasses for children: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for glasses for children.	New Item in the Summary of Cost and Coverage (SCC).
73.	D3	App D, Medical Benefits Information	Addition	HH. Dental check-up for children: The issuer will report either the copay as a fixed dollar amount or the co-insurance percentage for in network provider and out of network provider costs. Additionally, issuers will report limitations and exceptions for dental checkups for children.	New Item in the Summary of Cost and Coverage (SCC).

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
74.	D3-D4	App D, Medical Benefits Information: General information will include the following items.	Addition	Replace 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. with 75. 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.**	Clarification of item being collected.
76.	D4	App D, Medical Benefits Information: General information will include the following items.	Addition	Replace 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. with 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. In addition, a yes or no field will capture whether or not out-of-network charges apply to the out-of-pocket limit.**	Clarification of item being collected.
77.	D4	App D,	Edit	Replace	Clarification of item being

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Medical Benefits Information: General information will include the following items.		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. with G. **Additional** Office Visits: **In addition to the types of office visits mentioned above, issuers will be required to report on** the specified dollar amount, co-pay or coinsurance percentage associated with **periodic health exams, OB-GYN exam visits, and well baby care.**	collected.
78.	D4	App D, Medical Benefits Information: General information will include the following items.	Edit	Replace 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.** with H. **Drug benefits: In addition to the information on prescription drug coverage above, issuers will be asked to delineate the cost structure in relation to mail order to ascertain whether discounts are available, and indentify if an alternative tier structure of cost sharing is utilized.**	Clarification of item being collected.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
79.	D4	App D, Medical Benefits Information: General information will include the following items.	Addition	J. Vision Benefits: A description of vision benefits will be required, including whether there is a separate plan into which one is automatically enrolled, annual deductibles and maximums, coverage of general services as well as more expensive options such as surgery (e.g., corrective vision surgery).	New item collected through the Summary of Cost and Coverage (SCC).
80.	D4	App D, Medical Benefits Information: General information will include the following items.	Edit	Replace 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.** with O. Family Calculations (Individual Only): Some plans have separate family deductibles, out of pocket expenses, and/or maximums for coverage. **Issuers will be required to provide family deductibles and out of pocket maximums as set amounts for the maximum values or on a per person basis where appropriate.**	Clarification of item being collected.
81.	D4	App D, Medical Benefits Information: General information will include	Edit	Replace 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	Edit for clarification.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		the following items.		benefit amount. with Q. Mental Health Services: Coverage of mental health services **must be reported, including** 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.	
82.	D5	App D, Medical Benefits Information: General information will include the following items.	Edit	Replace 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. with R. Substance Abuse Treatment Coverage: Coverage of substance abuse treatment **must be reported, including** 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.	Edit for clarification.
83.	D5	App D, Medical Benefits Information: General information will include the following	Addition	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.	New data point being collected.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		items.			
84.	D5	App D, Medical Benefits Information: General information will include the following items.	Addition	T. Lifetime maximum: consumers need to be informed of the maximum benefit that issuers will cover.	New data point being collected.
85.	D5	App D, Medical Benefits Information: General information will include the following items.	Addition	U. Exclusions: Identified medical coverage and procedures which are excluded from service will be identified.	New item collected through the Summary of Cost and Coverage (SCC).
86.	D-5	Appendix D/Section B "Eligibility and Rating Information, Individual Market"	Addition	Section was originally in Appendix E in current PRA. The entire section was moved to Appendix D, in new PRA.	Consolidation of similar information to same Appendixes
87.	D-5	Appendix D/Section B "Eligibility and Rating	Addition	Text added to "B: Domestic Partnerships": *Does this include same sex domestic partners.*	Additional element requested by consumer advocates.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Information, Individual Market"			
88.	D-6	Appendix D/Section B "Eligibility and Rating Information, Individual Market"	Addition	Text added: "(L) Initial Community rating: Issuers will identify whether an individual's person health experience will be used exclusively for base price adjustments to the initial premium or whether some combination of personal and state experience (community rating) is utilized."	Additional data required to improve rating calculation
89.	D-6	Appendix D/Section B "Eligibility and Rating Information, Individual Market"	Addition	Text added: "(M) Renewal Community rating: Issuers will identify whether an individual's person health experience will be used exclusively for renewal price adjustments or whether some combination of personal and state experience (community rating) is utilized."	Additional data required to improve rating calculation
90.	D-6	Appendix D/Section B "Eligibility and Rating Information, Individual Market"	Addition	Text added: "(P) Offering Area: The set of zip codes which constitute the area in which the issuer is offering the plan for sale."	Additional data required to improve rating calculation
91.	D-6	Appendix D/Section B "Eligibility and Rating Information, Individual Market"	Addition	Text added: "(Q) Effective dates: In addition to plan effective dates, base rates may also undergo adjustments over time. Due to this, we will collect the start and end dates for which a set of rates may apply."	Additional data required to improve rating calculation
92.	D-6	Appendix D/Section B	Deletion	Text from current PRA removed in new PRA: "Lifetime maximum: consumers need to be informed	Under the new ACA law, lifetime limits on most benefits are

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		"Eligibility and Rating Information, Individual Market"		of the maximum benefit that issuers will cover."	prohibited in any health plan or insurance policy issued/renewed on or after September 23, 2010.
93.	D6	App D, Eligibility and Rating Information, Small Group Market	Edit	Replace "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." With "Pricing of small group market health insurance plans can be determined by a wide variety of factors **presenting unique challenges for producing premium estimates. In order to allow for consumers to quickly generate a reasonably representative price estimate, healthcare.gov will utilize a "limited census" approach in which small business owners would input general information about their company. This approach allows issuers to report more basic data which can still be used to develop a reasonable representation of a base price estimate."**	Edit for clarification.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
94.	D6	App D, Eligibility and Rating Information, Small Group Market	Addition	"Base Rates: Issuers will be required to provide a table including base rates for the given plan by age bands, gender, and user types. User types include employee only, employee and spouse, employee and child(ren), and family."	New data for the rating of the small group market.
95.	D6	App D, Eligibility and Rating Information, Small Group Market	Addition	"Effective Date Trend Factor: As small groups often have built in adjustments for increases in rates over time, issuers will be required to provide any multiplicative factors that may be appropriate based on an enrollee's projected start date."	New item for the rating of the small group market.
96.	D6	App D, Eligibility and Rating Information, Small Group Market	Addition	"Situs location factors: Issuers who adjust rates based on physical location of the work site will be required to provide multiplicative factors which can be applied based on the primary location of the work site by zipcode or other geographic indicator."	New item for the rating of the small group market.
97.	D6	App D, Eligibility and Rating Information, Small Group Market	Addition	"Size Factor: Issuers will be required to provide any multiplicative factor they use to vary rates based on the size of the company to be covered."	New item for the rating of the small group market.
98.	D6	App D, Eligibility and Rating Information, Small Group	Addition	"Industry Factor: Issuers will be required to provide any multiplicative factors they use to vary rates based on industrial classifications. Provision will be made for entry of these factors by either the Standard Industrial Classification (SIC) codes or the North	New item for the rating of the small group market.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Market		American Industry Classification System (NAICS)."	
99.	D6	App D, Eligibility and Rating Information, Small Group Market	Addition	"Initial Community rating: Issuers will identify whether an individual's person health experience will be used exclusively for base price adjustments to the initial premium or whether a combination of personal and group health experience, or on some combination of personal, group, and State experience (community rating) is utilized."	New item for the rating of the small group market.
100.	D6-7	App D, Eligibility and Rating Information, Small Group Market	Addition	"Renewal Community rating: Issuers will identify whether an individual's person health experience will be used exclusively for renewal price adjustments or whether a combination of personal and group health experience, or on some combination of personal, group, and State experience (community rating) is utilized."	New item for the rating of the small group market.
101.	D7	App D, Eligibility and Rating Information, Small Group Market	Edit	Replace "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." With "Specified rating factors: In some states ratings are allowed to vary based on gender and/or the inclusion of children. **In cases where the given rate estimation structure may not capture the appropriate dimensions, issuers will be asked to identify what additional factors are utilized. If non-identified factors create a strata for plan pricing, we will ask to be informed of those factors.**"	Clarification of item being collected.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
102.	D7	App D, Eligibility and Rating Information, Small Group Market	Addition	"Additional eligibility and cost factors will be collected so that this segment of the market can be understood, and the appropriate plans with the required level of detail can be displayed."	Differentiate the major rating factors for the small group market with additional and eligibility cost factors.
103.	D7	App D, Eligibility and Rating Information, Small Group Market	Addition	Replace "Domestic Partnerships: Can domestic partners be covered under this plan " With "Domestic Partnerships: Can domestic partners be covered under this plan, **and does this apply to same sex partners.**"	Clarification of item being collected.
104.	D7	App D, Eligibility and Rating Information, Small Group Market	Edit	Replace "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 must ascertain this to provide accurate quotes." With "Is the service area/rate structure based on the employer or employee location: **A plan's rates may be calculated based on place of employment or on an employee's place of residence.** We must ascertain this to provide **estimates of premium estimation.**"	Clarification of item being collected.
105.	D7	App D, Eligibility and Rating	Edit	Replace "Service area coverage: Must an employee live within the service area to be eligible?"	Clarification of item being collected.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Information, Small Group Market		With "Service area coverage: **In some cases, a service area may be defined within which an employee must reside for coverage. Issuers will be asked to identify if that is the case with a given plan, and whether that service areas boundaries correspond to the boundary of the state."**	
106.	D7	App D, Eligibility and Rating Information, Small Group Market	Edit	Replace "Minimum participation/contribution requirements: A specification of the minimal percentage of employees or employee contributions who would be required to enroll." With "Minimum participation/contribution requirements: A specification of the minimal percentage of employees or employee contributions **which** would be required **for enroll into the plan to be allowed**."	Edit for clarification.
107.	D7	App D, Eligibility and Rating Information, Small Group Market	Addition	"Effective dates: In addition to plan effective dates, base rates may also undergo adjustments over time. Due to this, we will collect the start and end dates for which a set of rates may apply."	New item for the rating of the small group market.
108.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"US citizenship. Is US citizenship required for plan membership."	Item not needed to determine cost/eligibility for small group market.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
109.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"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."	Item not needed to determine cost/eligibility for small group market.
110.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"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."	Item not needed to determine cost/eligibility for small group market.
111.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"Whether SIC or NAICS codes are used: An administrative field for identifying the types of employers who may be covered."	Item not needed to determine cost/eligibility for small group market.
112.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"Should out of state employees be given a rate or quoted $0?"	Item not needed to determine cost/eligibility for small group market.
113.	D7	App D, Eligibility and Rating Information,	Deletion	"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	Item not needed to determine cost/eligibility for small group market.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		Small Group Market		be used to determine whether this is the case."	
114.	D7	App D, Eligibility and Rating Information, Small Group Market	Deletion	"Other factors: If non-identified factors create a strata for plan pricing, we will ask to be informed of those factors."	Item not needed to determine cost/eligibility for small group market.
115.	D7	App D, Provisions for Association Plans	Addition	"Association plans constitute a growing segment of small group and individual health plans. These types of plans present particular challenges for knowing when to display the information for consumers. As such additional data will be collected to assist in understanding the best means for displaying this information for plans identified as association products."	Addition to account for collection of association plan information.
116.	D8	App D, Provisions for Association Plans	Addition	"Market: Given the variance in regulation, association plans do not always fall clearly into the predefined market structure. Thus these plans will be required to identify whether they are available for purchase by small groups, individuals or both."	New item to address association plans.
117.	D8	App D, Provisions for Association Plans	Addition	"Association name: Plans which are only available for purchase by members of an association must identify the name of that association."	New item to address association plans.
118.	D8	App D, Provisions	Addition	"Available to the general public: Some association plans allow for association membership by any	New item to address association plans.

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
		for Association Plans		member of the general public willing to join and pay the associated fees. Plans will be asked to identify if that is the case or if the association has more stringent rules regarding membership criteria."	
119.	D8	App D, Provisions for Association Plans	Addition	"Membership requirements: For those plans which identify their association as having requirements beyond payment of a fee, a brief specification of the minimal conditions for membership will be required."	New item to address association plans.
120.	D8	App D, Provisions for Association Plans	Addition	"Fee amount: Association plans will be required to identify the annual fee for basic individual membership aligned with the minimal membership conditions specified for that association."	New item to address association plans.
121.	D8	App D, Provisions for Association Plans	Addition	"Variable fee indicator: Plans which have a variety of membership fees based on differing levels of membership requirements will indicate that multiple membership levels and associated fees are available."	New item to address association plans.
122.	E1	App E, Sec A	Edit	Introductory paragraph, "While the primary source for information on product availability and costs are the insurance issuers, there is a set of readily available state data which allows us to verify the information obtained and assures that state regulatory authority is maintained. Additionally, for the consumer to gain an adequate understanding of state context and state resources we request that existing state sources of information be ascertained. This data was requested from the states by May 21, 2010 in order to provide a	Clarifications based on change since prior package

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				source against which vendor provided and issuer provided data may be compared." **BECOMES** "To gain information on what issuers were authorized to sell health insurance within a given state, an initial request was forwarded to the states for lists of registered insurance providers and certain basic information about the state which was believed to be of interest to consumers. This data was requested from the states by May 21, 2010 in order to provide a source against which vendor and issuer provided data may be compared. This request may be reiterated annually to present states with the opportunity to update their information."	
123.	E1	App E, Sec A	Deletion	Item G, "Feedback on issuer submissions: States will be provided with an opportunity to provide feedback on issuer submissions under the collection mandate" was deleted.	Consistent with recommendations from HHS-OGC.
124.	F-1	Appendix F	Deletion	Text removed: "May 21 Data Requirement"	No longer relevant
125.	F-1	Appendix F	Addition	"Health" added to first sentence: "One market of heightened interest to those without insurance currently are high risk pools."	Clarification
126.	F-1	Appendix F	Edit	Year updated from 2009 to 2011 in sentence: "These health benefits high risk pools operate in 35 states (as of 2009) but vary as to who is eligible, cost sharing requirements, and availability of premium subsidies."	Update to reflect current year
127.	F-1	Appendix F	Addition	Text added to last paragraph within introduction: "While State health benefits high risk pools are the ultimate source of information on these programs, this data has already been compiled by the National Association of State Comprehensive Health Insurance Plans (NASCHIP), and was provided to the government as of May 21, 2010. Voluntary updates	Clarification

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
				from plan administrators are allowed. The format of the data is included below."	
128.	F-1	Appendix F	Deletion	Text removed from last paragraph within introduction: "In order to minimize the burden on State health benefits high risk pools, the Secretary has arranged by agreement with NASCHIP to obtain the following set of elements for each high risk pool program by May 21, 2010."	Clarification