Revisions Crosswalk (CMS-10320): OMB 0938-1086
EDITS following issuer discussion after 60 Day review Period (current as of 10/7/2011)

(all pages refer to new)

Issue #	Page #	Section	Action to be performed	Changes to the Application	Reason for the Change
1.		App A, Section A, Background	Addition	As this data collection is intended to provide consumers with an appropriate educational experience for learning the affordable health insurance options available to them, it entails two separate collections of related information. Information on the individual market is collected at a portal plan (detailed) level, and comprises detailed benefits information, and data required to return estimated base rates returned from information provided by the consumer.	This section defines the data collection for individual products in general terms for clarity.
2.		App A, Section A, Background	Addition	Small group insurance is actually purchased in a different manner, such that small employers generally contract for a suite of products which allow their employees to choose between different options. Because of this, benefit information is collected as a set of available options with more general summaries. As base premiums would only apply after a small employers consumers choose between the available options, it was determined that base premiums could not be reliably collected and displayed. Instead, an estimate of cost per enrollee is calculated using enrollment and premium information reported.	This section defines the small group approach in general terms for clarity.
3.		App A, Section A, Background	Addition	Finally, it should be noted that other developments in the the Health Insurance market and its regulatory environment have impacted the collection. While we are not reporting on association products to consumers at this time, those products have increased their market share significantly over the last few years. Provisions are included in this PRA to allow for us to distinguish such	This section defines changes based on the emerging importance of association insurance products for clarity.

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				products from those which do not require membership in defined bodies. It is hoped that this lays the foundation for discussion with industry and consumers as to how best to display such information in the future.	
4.		App A, Section A, Background	Addition	A second development has been the emergence of a standard for reporting on health benefits and cost sharing to consumers which has emerged under the auspices of the NAIC. Referred to as the Summary of Benefits and Coverage, this standard is currently the foundation for reporting requirements which have been released for public comment as an MPRM covering transparency requirements in Section 2715 of the ACA. As this is an emerging standard, it was determined that the overall burden would be diminished if this data collection made similar adjustments. Section 1103 does require that we be consistent with any such emerging standard. This standard does request some additional information beyond the original specification. However, by adopting this standard, we can reduce the overall burden on issuers by providing a centralized location for providing this information to consumers, and allowing for one specification instead of several.	This addition explains the shift to using the Summary of Benefits and Coverage as the new standard for reporting in general terms. Added for clarity.
5.		App A, Section A, Background	Addition	These changes have evolved from prior experience with the initial collections and feedback received from industry, consumer representatives, and internal stakeholders. The new specifications of this package reflect those changes, as is made clear from the accompanying Revision Crosswalk.	Paragraph added for reading flow and to make clear that a cross walk of changes is available.
6.		App A, Section A, Background	Edit	Changed: This draft is being provided for the60 day period for comment by the public.	Reflect the stage of the process accurately.

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				To: A prior draft of this document was submitted for 60 day period for comment by the public. This version reacts to comments received, and provides the final version for 30 day review.	
7.		App A, Setion 4, Duplication of Efforts	addition	Additionally, in order to leverage the experience of issuers in this collection for other data requirements, it is anticipated that this portal will be utilized for other CCIIO collections such as rate review filings and possibly medical loss ratios.	Edit to delineate rationale for approach.
8.		App A, Setion 15, Changes to Burden	Edit	Change: The current estimate for the burden on issuers exceeds the initial annual estimate by $328,610. To: The current estimate for the burden on issuers is a reduction of $755,200 from the initial estimates provided in 2010.	The comment was confusing, as the change was not based on the original estimate, but on a revised estimate for a period covered by an interim PRA. The numbers are further explained through the addition of a chart
9.		App A, Setion 15, Changes to Burden	Addition	Table added with numbers from emergency PRA submission 08/09/2010, and replication of existing chart within current document showing current costs.	Added at OMB request.
10.		App C, Subsequent Data Collection, M(c)	Added	Authorized Data Attestation Officials: Two factor authentication will require that basic contact information will need to be collected.	Security requirements for two factor authentication required a change to attestation such that email and phone information now be collected for attestors (CEO/CFO). This security change has not yet gone into production, and issuers will be notified before implementation.

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11.		App C, Subsequent Data Collection Section N	Deletion	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.	The set of questions regarding general corporate information has been removed, which allowed for removing one submission template from the requirements.
12.		App C, Subsequent Data Collection Section C	Inserted	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.	Question added based on discussion with industry. Including this question will allow for more accurate reporting of denials.
13.		App C, Subsequent Data Collection Section G		Chnaged: Additional types of insurance product statuses will also be included, such as association product status and whether a product has been grandfathered. To: 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.	Edited for clarity - designation as association or as grandfathered are now two separate fields.
14.	D-1	App D, September 3 Data Requirement: Benefits and Pricing	Deletion	B. Portal Plan enrollment: Number of covered lives for the most recent completed fiscal quarter.	Based on comments by industry, enrollment will no longer be captured at both product and portal plan level to reduce burden and concerns over confidentiality.
15.	D-6	App D, Medical Benefits	Insertion	Medical Benefits Information- Small Group Market While the decision was made to utilize the “Summary of Benefits and Coverage” (SBC) developed by the	In prior versions of the PRA, the areas of coverage for small group and individual products

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		Information-Small Group Market		insurance industry and regulators through the National Association of Insurance Commissioners (NAIC), it is recognized that this is especially problematic for small group products in which a particular portal plan is not specified at the time a small employer enrolls with an insurer. As such, a modified approach to identify the set of cost sharing benefits at a product level is being proposed as delineated below. The following items will be collected in the format consistent as possible with the SBC at a product level. A. HSA Eligible: Insurers will need to indicate this information under the instruction to Enter Y or N B. Annual Deductible, In Network: Insurers will need to indicate this information under the instruction to Enter the available deductibles separated by commas (ex 1000, 2000, 2500, etc.)" C. Annual Deductible, Out of Network: Insurers will need to indicate this information under the instruction to Enter the available deductibles separated by commas (ex 1000, 2000, 2500, etc.)" D. Copay, In Network: Insurers will need to indicate this information under the instruction to Enter the minimum and maximum copay separated by commas (ex 0, 50)" E. Copay, Out of Network: Insurers will need to indicate this information under the instruction to Enter the minimum and maximum copay separated by commas (ex 0, 50)" F. "Coinsurance, In Network: Insurers will need to indicate this information under the instruction to Enter the minimum and maximum coinsurance	were listed together. The sections have now been separated. This is to allow us to distinguish between how the are answered. While individual benefits are still collected at a plan level which allows for detailed response, small group is reported at product level, and issuers select from a drop down box with four options. This section is entered as a block to emphasize it duplicates what already existed except for being moved to a new section and the detailed reporting changed for each field to “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” (10/6/2011)

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				separated by commas (ex 0%, 40%)" G. "Coinsurance, Out of Network: Insurers will need to indicate this information under the instruction to Enter the minimum and maximum coinsurance separated by commas (ex 0%, 40%)" H. Annual Out-of-Pocket Limit, In Network: Insurers will need to indicate this information under the instruction to Enter the maximum annual out of pocket net of deductibles, copay and coinsurance." I. Annual Max Benefit, In Network: Insurers will need to indicate this information under the instruction to Enter the highest annual max benefit" J. Overall Deductible: Insurers will need to indicate this information under the instruction to K. Other deductibles for specific services: Insurers will need to indicate this information under the instruction to L. Out-of-Pocket limit: Insurers will need to indicate this information under the instruction to M. Not included in Out-of-Pocket: Insurers will need to indicate this information under the instruction to N. Overall annual limit on insurer payment: Insurers will need to indicate this information under the instruction to O. Does the plan use a network of providers?: Insurers will need to indicate this information under the instruction to P. Specialist referral required?: Insurers will need to indicate this information under the instruction to Q. Are there services this plan doesn't cover?: Insurers will need to indicate this information under the instruction to	

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				R. Primary care visit to treat an injury or illness: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" S. Specialist visit: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" T. Other practitioner office visit: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" U. Preventive care/screening/immunization: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" V. Diagnostic test (x-ray, blood work): Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" W. Imaging (CT/PET scans, MRIs): Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" X. Generic drugs: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" Y. Preferred brand drugs: Insurers will need to indicate this information under the instruction to	

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				enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” Z. Non-preferred brand drugs: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” AA. Specialty drugs (e.g., chemotherapy): Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” BB. Outpatient facility fee (example, ambulatory surgery center): Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” CC. Outpatient Physician/ surgeon fees: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” DD. Emergency room services: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” EE. Emergency medical transportation: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” FF. Urgent care: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations,	

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				Covered at Additional Cost" GG. Hospitalization facility fee (example: hospital room): Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" HH. Hospitalization Physician/surgeon fee: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" II. Mental/Behavioral health outpatient services: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" JJ. Mental/ Behavioral health inpatient services: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" KK. Substance use disorder outpatient services: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" LL. Substance use disorder inpatient services: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" MM. Prenatal and postnatal care: Insurers will need to indicate this information under the instruction to	

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				enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” NN. Delivery and all inpatient services: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” OO. Home health care: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” PP. Rehabilitation services: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” QQ. Habilitation services: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” RR. Skilled nursing care: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” SS. Durable medical equipment: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” TT. Hospice service: Insurers will need to indicate this information under the instruction to enter “Covered, Not Covered, Covered with Limitations, Covered at Additional Cost” UU. Eye exam: Insurers will need to indicate this information under the instruction to enter	

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				"Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" VV. Glasses: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" WW. Dental check-up: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" XX. Acupuncture: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" YY. Bariatric Surgery: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" ZZ. Non-emergency care when travelling outside the U.S.: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" AAA. Chiropractic Care: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" BBB. Cosmetic Surgery: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" CCC. Dental care (adult): Insurers will need to indicate this information under the instruction to	

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				enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" DDD. Hearing aids: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" EEE. Infertility treatment: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" FFF. Long-term care: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" GGG. Private-duty nursing: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" HHH. Routine eye care (adult): Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" III. Routine foot care: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost" JJJ. Weight loss programs: Insurers will need to indicate this information under the instruction to enter "Covered, Not Covered, Covered with Limitations, Covered at Additional Cost"	
16.	D-6	App D, Eligibility and Rating	Deleted	Replace "***Eligibility and Rating Information, Small Group***	After discussion with industry, the approach for displaying a cost to consumers was changed. This list

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		Information		***Market*** 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. A. 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. B. 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. C. 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.	of elements necessary to collect and report base rates was eliminated. It is replaced by a single element listed separately.

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				D. 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. E. 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 American Industry Classification System (NAICS). F. 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. G. 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. H. 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	

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				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.	
17.	D6	App D, Eligibility and Rating Information	Addition	"***Eligibility and Rating Information, Small Group Market*** Pricing of small group market health insurance plans is difficult to identify with specificity beforehand, as small employers will often shop for a product which provides a range of choices to their members. As such, it can be difficult to identify a particular cost point, even though they still need to be able to assess the cost impact on them. As a solution to this difficulty, an approach is being utilized which shows the average cost per covered life within a product. This has an additional advantage of significantly reducing the cost of reporting. A. Total written premiums: Issuers will report the sum total of written premiums over the course of an annual quarter for the specified small group product. This number will be divided by the number of covered lives reported."	This single element is being used in conjunction with enrollment to produce a cost estimate. This approach was adopted after discussion with industry and internal stakeholders.
18.	D-8	App D, End of document	Edit	***Business Rules Information, Small Group Market***	This content was previously included under the deleted section

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				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. A. 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. B. 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. C. 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. D. Service area coverage: In some cases, a service area may be defined within which an employee must reside for coverage.	regarding rating. It has been moved after the single element for total written premium. This move is purely administrative.

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				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. E. 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. F. 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.	
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