Supporting Statement – Part A

Supporting Statement for Essential Health Benefits Benchmark Plans

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act implements various policies that will make health insurance coverage more accessible to consumers. New competitive private health insurance markets ("Exchanges") will give millions of Americans and small businesses access to affordable, quality insurance options. Exchanges will help individuals and small employers shop for, select, and enroll in private health plans that fit their needs at competitive prices. By providing a place for one-stop shopping, Exchanges will make purchasing health insurance easier and more transparent, and will put greater control and more choice in the hands of individuals and small businesses.

Pursuant to Section 1302 of the ACA and Section 2707 of the Public Health Service Act, as amended by section 1201 of the ACA, CMS released a bulletin on December 16, 2011 (EHB Bulletin) describing its intent to define Essential Health Benefits (EHB) by reference to a State-specific benchmark plan. In order to establish EHB benchmark plans in each State, CMS will collect data from the limited set of potential default benchmark plan issuers in each State and from States that select their own benchmark. CMS also intends to ask all States for a voluntary submission of their State mandated benefits. This data collection is based on the collection of benefits currently collected in HealthCare.gov, will be collected via the tools supporting HealthCare.gov (the Health Insurance Oversight System), and is information which will be used to inform consumers regarding their affordable Health Care options.

We also plan to collect submissions from dental plan issuers on whether they intend to apply for certification to participate in the Exchanges as stand-alone plans.

B. Justification

1. Need and Legal Basis

Title I of the ACA calls for the establishment of State-level health insurance Exchanges. If a State opts not to pursue an exchange, the Federal government will establish a Federally-facilitated Exchange (FFE) in the State. Section 1301 of the ACA requires that all qualified health plans (QHPs) offered in the Exchanges provide the EHB as defined by the Secretary subject to section 1302. Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under title I of the ACA, and the requirement to offer the EHB also extends to non-grandfathered individual and small group market plans offered outside of the Exchanges pursuant to section 2707 of the Public Health Service Act as amended by section 1201 of the ACA. Collection of data on EHB benchmark options is essential to this provisioning.

On June 5, 2012, HHS published the NRPM CMS-9965-P, "Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans," authorizing CMS to collect data from potential default benchmark plan issuers in each State. The information collection requirement (ICR) associated with that proposed rule addressed States that select their own benchmark. The proposed rule was finalized and published on July 20, 2012. CMS requests that all States make a voluntary submission of their State mandated benefits. We encourage States to voluntarily submit this information, regardless of the State selection of a benchmark. CMS also requests that issuers submit dental plan information on whether they intend to apply for certification to participate in the Exchanges as stand-alone plans.

2. Information Users

The EHB information will be used by CMS to establish the default benchmarks in States that do not select a benchmark plan and to verify State benchmark selections. This then allows insurance issuers seeking to offer coverage in the individual and small group markets in various States to design benefits that meet EHB, including QHPs deciding whether to offer a pediatric dental benefit. The information will be used to inform CMS and States, as well as the FFE and State-based Exchanges (SBEs) in their efforts to ensure plans are meeting EHB requirements for QHP certification and outside market compliance. All together, this will allow HealthCare.gov to inform consumers regarding the EHB appropriate to their State.

3. Use of Information Technology

CMS will be leveraging the Health Insurance Oversight System (HIOS) for the collection of the data set forth in this package. HIOS has been used by all health insurance companies in the individual and small group market nationwide since 2010 for reporting to CMS for www.HealthCare.gov, Federal Rate Review, and Medical Loss Ratio. Prior to the launch of each of these programs CMS has worked with issuers to modify HIOS as appropriate. CMS aims to lessen the burden on issuers and minimize the need for any start-up costs for the required submission by using HIOS.

4. Duplication of Efforts

There is no duplication of efforts. This is a new data collection.

5. Small Businesses

Small Businesses are not significantly affected by this collection.

6. Less Frequent Collection

We anticipate that the EHB benchmark data collection will occur no more frequently than every two years.

7. Special Circumstances

It is anticipated that respondents for the EHB data collection will be required to submit the data fewer than 30 days after the PRA package and authorizing final regulation are published. The collection of benefit and limit information from issuers will occur from August 20-September 4, 2012. States will be encouraged to submit State selections by September 30, 2012. This is necessary to allow plans to provide data about potential benchmarks, allow CMS to review the data and then publish the actual benchmark plans shortly thereafter for each State in a HHS benefit and payment notice. Timeliness is critical to allow sufficient time for potential QHPs to design benefits that comply with the benchmark, gain necessary State approvals and eventually be certified by Exchanges as QHPs prior to the October 1, 2013 initial enrollment date.

8. Federal Register/Outside Consultation

EHB provisions have been subject to substantial discussion and consultation with the public and the affected industry. Review and comment was managed primarily through publication of the EHB Bulletin on December 16, 2011. Additional comment was collected through the publication of the proposed regulation (CMS-9965-P) accompanying this PRA submission. That proposed rule was finalized and published in the Federal Register on July 20, 2012 (CMS-9965-F).1

9. Payments/Gifts to Respondents

No payments or gifts were made to any respondents.

10. Confidentiality

To the extent provided by law, we will maintain respondent privacy with respect to the information being collected. CMS intends to publish the EHB data on benefits and limits associated as necessary for the determination of final benchmarks. HealthCare.gov collects issuer opinions regarding confidentiality of any new data elements for review by the FOIA office at CMS.

11. Sensitive Questions

1 Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-07-20/pdf/2012-17831.pdf.

No sensitive questions are asked in this data collection.

12. Burden Estimates (Hours & Wages)

The burden associated with this data collection can be attributed to certain health insurance issuers and States. To reduce the burden on issuers and States, the benefit data collection is similar to the collection in HealthCare.gov.

Burden on Issuers

As stated in section 156.120, health insurance issuers that offer the three largest products by enrollment in each State's small group market must provide certain information related to benefit coverage to HHS, the State, and the Exchange. We estimate that it will take four hours for a health insurance issuer to meet this reporting requirement, including data collection, submission, and validation. This estimate is based on current industry surveys collected to monitor the burden of submission of similar data in the Medicare Advantage and Prescription Drug Programs. Given that the three health insurance issuers with the largest products by enrollment in each State (including the District of Columbia) have to submit this information, the total burden is estimated to be 612 hours. We anticipate that the reporting requirement will require one employee at a cost of $77.00 an hour, based on the hourly cost reported by industry in responses to a CMS survey of Medicare Advantage and Prescription Drug Programs which requires employees with similar technical expertise, for a total cost of $308.00 a year per issuer. The total number of respondents required to report will be 153, the top three issuers/products in each State and the District of Columbia by enrollment, for a total burden of $47,124.

Below is the estimate of the burden imposed on a single health insurance issuer subject to the reporting requirements of this rule.

Data Element	# of Employees Needed	Cost of Reporting	Burden Hours	Cost of Reporting (per response)	# of Responses per respondent (per year)	Total Burden Hours (per year)	Total Burden Costs (per year)
Benefit Submission	1	$77.00	4	$308.00	1	4	$308.00

Below is the estimate of the burden across all respondents who are subject to the reporting

requirements of this rule.

Data Element	# of Respondents	Total Number of Responses (all respondents)	Total Number of Hours (per year)	Total Burden Cost (per year)
Benefit Submission	153	153	612	$47,124

Burden on Dental Plan Issuers

CMS is also requesting that issuers that intend to offer stand-alone dental plans in any State Exchange or in the FFE notify CMS of their intent to participate. This collection includes data on whether the issuer intends to offer stand-alone coverage, the anticipated Exchange market in which coverage would be offered, and the State and service area in which the issuer offers coverage. The burden associated with meeting this requirement includes the time and effort needed by the issuer to report on whether it intends to offer stand-alone dental coverage. We estimate that it will take one half hour for a health insurance issuer to meet this reporting requirement. We estimate that approximately 20 issuers will respond to this data collection. Therefore, the total burden is estimated to be 10 hours.

Below is the estimate of the burden imposed on a single health insurance issuer subject to the reporting requirements of this rule.

Data Element	# of Employees Needed	Cost of Reporting	Burden Hours	Cost of Reporting (per response)	# of Responses per respondent (per year)	Total Burden Hours (per year)	Total Burden Costs (per year)
Benefit Submission	1	$38.50	.5	$38.50	1	.5	$38.50

Below is the estimate of the burden across all respondents that we estimate will respond to the reporting request.

Data Element	Estimated # of Responses	Total # of Responses (all respondents)	Total Number of Hours	Total Burden Cost (per year)

Notice of Intent to Apply	20	20	10	$1540.00

Burden on States

States that select a benchmark plan will also need to submit this information on their State selection. We estimate the burden on each individual State will be 5 hours to make a benchmark determination, compile the data, and submit the information in the required format to HHS. However, if a State selects as its benchmark one of the three largest small group market benchmark options, for which HHS is collecting data to establish default benchmarks, the State may choose to rely on the issuer submission and provide HHS with only the name of the plan and other necessary identifying information. In this situation we believe the burden will be less than five hours. There is no way to accurately predict how many States will decide to select their own benchmark plan at this time, but we estimate that the burden on each State will be similar to the issuer burden, with the additional aspect of ensuring coverage in each of the 10 statutorily required categories.

13. Capital Costs

There are no anticipated capital costs associated with this data collection.

14. Cost to Federal Government

There are no additional costs to the Federal government.

15. Changes to Burden

This is a new data collection.

16. Publication/Tabulation Dates

The results are expected to be analyzed, verified, and published for public comment and then finalized.

17. Expiration Date

CCIIO has no objections to displaying the expiration date.

18. Certification Statement

There are no exceptions to the certification statement.