Data Collection for HealthCare.gov

CMS responses to comments received regarding regulations.gov
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New Data Templates

The new individual and family plan benefits template includes 33 new required "limitations and exceptions" fields that have been expanded to accommodate the SBC requirements. While we understand that these fields are necessary for HHS to generate a SBC, they pose several operational challenges and in some circumstances we recommend they are optional. While the previous allowable response was "limitations and exceptions may apply" or "none" now health plans are required to include free text to describe the most significant limitations and exceptions including dollar or service limitations. Making this field optional would eliminate the need for those plan benefits that do not have limitations and exceptions to be filled out. In addition, it would eliminate the need for those companies who will not be using Healthcare.gov for "deemed compliance" for the SBC requirements to complete. For these companies, the site could just reference the benefit brochure which already includes the same information. We recognize that this data is somewhat detailed, and the templates will incorporate optional status for a number of elements. However, based on the desire for consistency in reporting, HealthCare.gov will be using the SBC format for display and as such needs to be able to populate those fields. Issuers will be creating SBCs under a variety of conditions, so the burden associated with defining what should populate the fields is minimal. The issue of referring people to published brochures elsewhere would not meet the statutory requirement of collecting and displaying the information on one site where consumers can compare their options. We will entertain additional suggestions specifically raised regarding how we may incorporate third party sites in future. Currently, we allow for xml submissions which could be generated by the same computer systems used to create SBCs for mailing.

We recommend that HHS takes steps to allow plans to review their SBC's before they are published online to address any data issues early. We also recommend that HHS use the first two data submission windows to make any needed changes to the SBC generation process. We recognize that reviewing SBCs as they are created and before publication is desirable by Issuers. We will attempt to address this moving forward. Currently, technical issues associated with creating 508 compliant versions of thousands of documents associated with the collection will not allow adequate time for this review in the initial collection. Additionally, CMS has always separated out issuer responsibility for submission from CMS responsibility for display. This stance is essential to make sure objective standards for comparison information are applied. CMS will retain this ultimate responsibility for the display.

We recommend that the new data templates are migrated to Excel 2010. Currently HHS only supports Excel 2003 and XML. Many health plans are phasing out older version of Microsoft office and the web portal's use of Excel 2003 creates workarounds in the support areas. We

recommend HHS update the data collection templates to Excel 2010 for the August 2012 combined submission window. We appreciate the desirability of Excel 2010 support, and will be implementing this change with this next collection.

Given the new fields, we recommend that HHS release an updated confidentiality template with the finalization of the templates next month. CMS will be including an updated template to collect confidentiality concerns.

Technical Recommendations

Submission of product level data thru the Health Insurance Oversight System (HIOS): The HIOS submission process continues to pose challenges in that each issuer is contained in separate spreadsheets. Simple contact changes often require health plans to have to change multiple files with duplicate information. We recommend a similar approach is taken to RBIS where the data is all included on one file. While we strive to minimize duplicative data entry, issuers have been clear with us that different individuals may have responsibility for submitting data in different states. The current design maximized the flexibility for issuers to indicate different responsibility. Some issuers may have a fewer responsible parties. We will take this under advisement to see if we can implement a default to primary user in future iterations, but this would require significant changes to the data structure at this time. As CMS moves to consolidate future collection efforts, we will be revising the user management system and will attempt to address this concern.

New Data System: We understand that HHS is upgrading to a new data collection system in August. We request information on this new system as soon as possible so health plans can make any necessary adjustments to their operational processes. CMS has already provided two training sessions to review the new structure for open collection periods. Weekly calls are held with issuers to address any other questions which may emerge. Detailed user guides have been prepared and only await finalization of collection authority before dissemination. Help desk service and email are also available for questions.

Zip Code Timing Issue: RBIS validates the zip codes on the regions template at submission time against real time data at the United States Postal Service (USPS). Health plans are using a CD provided by the USPS which is updated monthly. Therefore, health plans are seeing zip code errors due to timing differences of the source of zip code data. HHS should work to synch up the timing by allowing health plans to access the same zip code data that HHS is using. An alternative is for HHS to clearly specify at each data collection what version of the USPS data they are using. CMS has contracted for continuously updated zip code information. We are bound by contract from sharing this data directly. We review submitted information to make sure that issuers have appropriate definitions of regions in place to assure them that the proper information is provided to consumers. Initially, reports of errors were not detailed enough for easy editing of submitted files, and we have attempted to improve the content of our error messages. Issuers are ultimately responsible for appropriate definitions of their rating regions.

Auto Generated Emails: We recommend that the HIOS “Submission Error” and HIOS “Submission Successful” emails include the state abbreviation and Issuer ID in the subject line to allow for routing to the responsible parties. CMS appreciates that this may be a good idea, as

different parties may be responsible for different states. We will take under advisement and attempt to include in future iterations.

Link Failures: We recommend that HHS provide descriptive failure link notifications before the data submission window closes. This will allow health plans with sufficient time to make any necessary adjustments. CMS does review and notify issuers regarding problematic links. This is a manual process, and requires time to complete. We need to have complete data in order to be able to review it, and we typically review and send notifications within 3 days. In our future collection design, data submission windows for HIOS will only be closed for two weeks each quarter, allowing issuers a substantial window for addressing problems.

Attestation: Issues with attestation have been a long-standing source of reporting burden. We recommend the following changes are made to the attestation process:
o The "Ready for Attestation" and "Attestation complete" emails do not contain the state in the subject line. We recommend that HHS include the state name in the "Ready for Attestation" email and "Attestation complete" email so that it matches the attestation page in RBIS.
o CEOs/CFOs who are attesting on behalf of their companies continue to receive successful submission auto generated email messages for the HIOS system. This causes confusion and unnecessary processing by health plans especially because CEOs/CFOs are not required to attest to the HIOS data. We appreciate that attestation officials (CEOs and CFOs) have substantial demands on their time. They are required to attest as to the entirety of their submission, including the HIOS data. We are attempting to simplify and streamline this process, including an online facility which allows them to attest when submissions are completed in their entirety. We are seeking ways to reduce emails while making sure these individuals are informed moving forward.

Data Submitter and Validator Roles: We recommend the following changes are made to the attestation process:
o Submitter and Validator roles cannot see what the Attester is seeing on the attestation screen. We recommend that HHS provide "view only" access to the Submitter and Validator roles in order to view what the Attester will see on the Attestation screen.
o The attestation page does not clearly display all Issuers available for Attestation at one time. We recommend the page distinguish which Issuers had data submitted and which did not in a table vs. using a scrolling box. We will consider allowing submitters to view the attestation page versus using email notifications. Nevertheless, views of the information are consistent and should not present substantial problems. Based on your second suggestion, we will be changing the display to provide a full table rather than a display window for lists of submissions within HIOS.