Appendix D - Benefits and Pricing

September 3 Data Requirement: Benefits and Pricing

As Section 1103(b)(2) makes clear, the ability of consumers to decide on affordable health care options requires additional information on benefits and cost sharing associated with a product. Specifically, the Secretary requires information on the "percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options."

To ensure accurate information, consistent presentation, and to minimize the burden on issuers, collection of this data was delayed until after the May 21, 2010 collection. As of September 3, 2010, however, issuers have been required to provide information on the portal plan level. The general structure of these elements remains unchanged from prior collections approved under control number 0938-1086 (this HealthCare.gov PRA), but moving forward the operationalization of some of these elements has been revised to be consistent with collection under OMB control number 0938-1146. These specific changes are delineated in Appendix G-2.

Portal Plan General Information

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.

Medical Benefits Information

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.

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.
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.
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.
D. Preventive care/screening/immunization: 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 preventive care, screenings, and immunizations.

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).
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).
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.
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. Additionally, issuers will report limitations and exceptions.
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.
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.
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.
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).
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).
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.
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 will report limitations and exceptions for emergency room services.
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.
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.
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).

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.
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 and exceptions for mental and behavioral health outpatient services.
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.
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.
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.
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.
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.
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.
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.
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.
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.
DD. Durable medical equipment: 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 durable medical equipment.
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.
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. Additionally, issuers will report limitations and exceptions for eye exams for children.
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.
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.

General information will include the following items.

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. 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.
B. Coinsurance: We will require a brief description of when co-insurance is applied, and what percentage is covered.
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.
D. Primary Care Physician Required: Issuers will be required to indicate whether a primary care physician must be specified under the plan. This factor has significant effects on the relationship between a patient and their doctor, and as such is of importance to consumers, thus the Secretary will require it be reported.
E. Specialist Referrals Required: issuers will need to indicate to consumers whether a referral from their primary care physician is needed before seeing a specialist.
F. HSA Eligibility: Health Savings Accounts HSAs are one avenue used by many consumers to manage overall health care expenses. We will ask whether HSAs are supported under the plan.
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.
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.
I. Dental Benefits: A description of dental benefits will be required, including whether there is a separate plan into which one is automatically enrolled, annual deductibles and maximums, coverage of general preventative procedures as well as more expensive options such as dental surgery and orthodontics.
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).
K. Out-of-Network Coverage: A yes or no field regarding whether out of network care is covered combined with brief descriptions of the plan on this aspect will be required (including deductible, coinsurance, out-of-pocket-limit, and pre-authorization requirements).
L. Out-of-Country Coverage: A yes/no or short description of whether care obtained outside the country is covered under the plan. This information may be of critical importance to consumers who travel internationally.
M. Medical Records coverage: Are the costs of obtaining medical records covered under the plan.
N. Self directed account: (Small Group Only) A Self Directed Account is a health insurance plan that provides an annual dollar credit that can be used to pay for covered services. Any unused portion of the dollar credit may be carried over and added to the next year's credit if continuously enrolled in the plan. This information will be collected for small group plans.
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.
P. Chiropractic Services: Coverage of chiropractic services will be requested and include whether services are covered and how charges relate to the deductible, percent co-pay or co-insurance, number of visits per year, and maximum benefit amount.

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.
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.
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.
T. Lifetime maximum: consumers need to be informed of the maximum benefit that issuers will cover.
U. Exclusions: Identified medical coverage and procedures which are excluded from service will be identified .

Eligibility and Rating Information, Individual Market

Various factors go in to the calculation of an individual consumer's out-of-pocket expenses for an insurance package. Currently, many states allow for medical under-writing which can affect a person's actual premiums through such issues as life-style choices and pre-existing medical conditions. To accurately reflect these issues, it will be imperative to gather information about how the issuer determines insurance rates.

The secretary will explore the best way to reflect these myriad differences in pricing schemes to provide the best estimate of costs possible. The data requirement will cover:

A. US citizenship. Is US citizenship required for plan membership.
B. Domestic Partnerships: Can domestic partners be covered under this plan. Does this include same sex domestic partners.
C. 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.
D. Other eligibility requirements: In cases where other non-health related questions are used to determine eligibility, the secretary will require that these be specified.
E. Age limits: Some plans have a maximum or minimum age for either primary applicants or for dependents. In cases where this is true, we will those limits will be noted.
F. Effective Dates: Given enrollment periods may sometimes differ, as can the time period during which rates are in effect. issuers will be required to identify the appropriate dates.
G. How often do rate updates typically occur?
H. Other categories: issuers in different states may apply a variety of specific non-medical conditions for membership or for the application of different pricing schemes. Plans may be limited to non-smokers, available only to particular occupations, or be subject to any number of limits. Where such categorical determinations exist, the issuers will be required to identify them.
I. Administrative Fees: If monthly fees are required by the plan, we will require that they be specified for the consumer.
J. Issuer fee Conditions: If issuer fees are applied, issuers will be required to identify the conditions for their application and calculation.
K. Rate calculation: Individual rates may be calculated on a number of different dimensions even before medical underwriting or even if medical underwriting doesn't apply. Issuers will be required to provide information on how their rates are calculated. It is anticipated that most issuers will be able to provide this by use of a "rate table" providing a breakdown by variables such as gender, age, smoking status, and a few additional variables. In cases where such

tables do not adequately describe rating by the issuer, the issuer will provide a programmatic description of their rating formula in a step by step formula. Where issuers maintain a verification source which allows for third party comparisons, this information will be provided to allow the Government to review results from whatever calculations are required on our part.

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.
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.
N. Additional administrative specifications: Some factors related to how data must be specified for purposes of filling out applications or other forms will be ascertained. In some cases, issuers may have specific requirements on how forms must be filled out (such as children and spouses should be listed in age order).
O. 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.
P. Offering Area: The set of zip codes which constitute the area in which the issuer is offering the plan for sale.
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.

Eligibility and Rating Information, Small Group 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.
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 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.

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.

I. Domestic Partnerships: Can domestic partners be covered under this plan, and does this apply to same sex partners.
J. Age limits: Some plans have a maximum or minimum age for either primary applicants or for dependents, and for small groups this may be affected by the size of the group. This information will be captured through a short series of questions.
K. 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.
L. 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.
M. Fees: Issuers will be required to identify whether there are application or administration fees which consumers should factor into their decision.
N. Coverage area administrative specifications: To determine the appropriate path for rate estimation, questions will be asked regarding whether the determination of service areas is determined in the same way across plans and states.
O. 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.
P. Administrative calculation factors: While most data elements are being collected to display to consumers or fed directly into rate calculations, others may simply be important for determining the best approach to incorporate their data. These issues will be covered by a small set of questions such as the minimum time in business rules, whether rates are calculated on the basis of tables or through algorithms and a rating engine, and where verification data may be found if new algorithms must for required by issuers.
Q. Rate calculation specifications: In order to validate and develop ratings solutions, issuers will be asked to provide a step-by-step description of their ratings process.
R. 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.
S. 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.

Provisions for Association Plans

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.

A. 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.
B. Association name: Plans which are only available for purchase by members of an association must identify the name of that association.
C. Available to the general public: Some association plans allow for association membership by any 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.
D. 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.
E. 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.
F. 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.