

## **Appendix B - Benchmark Plan Data Requirements**

In accordance with CMS-9965-F, “Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans,” CMS will collect data from 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. We encourage States to voluntarily submit this information, regardless of the State selection of a benchmark. CMS intends to ask issuers to submit dental plan information on whether they intend to apply for certification to participate in the Exchanges as stand-alone plans.

This data collection is based on the collection of benefits currently collected in HealthCare.gov. CMS plans to collect benefit data on the 45 benefits currently collected in HealthCare.gov and also includes: the administrative data necessary to identify the health plan, data on covered benefits, quantitative treatment limitations on those benefits, data on drug coverage, and enrollment.

CMS expects that the data collection will collect benefit information from 153 issuers. We cannot currently predict how many States will decide to select an essential health benefits (EHB) benchmark plan.

The following lays out the specifics of the elements to be collected. Administrative data which has already been submitted to HealthCare.gov will be pre-populated where possible. This document begins by identifying the benefits to be collected. Next it delineates the limitations and other information associated with those benefits.

It then goes on to delineate the administrative information, the collection of drug data, the data elements associated with the State mandates to be collected on a voluntary basis from States, the elements to be collected from dental plan issuers who plan on participating in the Exchanges, and the data elements associated with identifying each state benchmark.

### ***Health Benefit Data Elements***

1. Primary Care Visit to Treat an Injury or Illness - Report limitations and other relevant data for primary care visit.
2. Specialist Visit - Report limitations and other relevant data for specialist visit.
3. Other Practitioner Office Visit (Nurse, Physician Assistant) - Report limitations and other relevant data for other practitioner office visit.
4. Outpatient Facility Fee (e.g., Ambulatory Surgery Center) - Report limitations and other relevant data for outpatient facility fee.

5. Outpatient Surgery Physician/Surgical Services - Report limitations and other relevant data for outpatient surgery physician/surgical services.
6. Hospice Services - Report limitations and other relevant data for hospice services.
7. Non-Emergency Care When Traveling Outside the U.S. - Report limitations and other relevant data for non-emergency care when traveling outside the U.S.
8. Routine Dental Services (Adult) - Report limitations and other relevant data for adult routine dental services.
9. Infertility Treatment - Report limitations and other relevant data for infertility treatment.
10. Long-Term/Custodial Nursing Home Care - Report limitations and other relevant data for long-term/custodial nursing home care.
11. Private-Duty Nursing - Report limitations and other relevant data for private duty nursing.
12. Routine Eye Exam (Adult) - Report limitations and other relevant data for adult routine eye exam.
13. Urgent Care Centers or Facilities - Report limitations and other relevant data for urgent care centers or facilities.
14. Home Health Care Services - Report limitations and other relevant data for home health care services.
15. Emergency Room Services - Report limitations and other relevant data for emergency room services.
16. Emergency Transportation/Ambulance - Report limitations and other relevant data for emergency transportation/ambulance.
17. Inpatient Hospital Services (e.g., Hospital Stay) - Report limitations and other relevant data for inpatient hospital service.
18. Inpatient Physician and Surgical Services - Report limitations and other relevant data for inpatient physician and surgical services.
19. Cosmetic Surgery - Report limitations and other relevant data for cosmetic surgery.
20. Bariatric Surgery - Report limitations and other relevant data for bariatric surgery.
21. Skilled Nursing Facility - Report limitations and other relevant data for skilled nursing facility.
22. Prenatal and Postnatal Care - Report limitations and other relevant data for prenatal and postnatal care.
23. Delivery and All Inpatient Services for Maternity Care - Report limitations and other relevant data for delivery and all inpatient services for maternity care.
24. Mental/Behavioral Health Outpatient Services - Report limitations and other relevant data for mental/behavioral health outpatient services.
25. Mental/Behavioral Health Inpatient Services - Report limitations and other relevant data for mental/behavioral health inpatient services.
26. Substance Abuse Disorder Outpatient Services - Report limitations and other relevant data for substance abuse disorder outpatient services.
27. Substance Abuse Disorder Inpatient Services - Report limitations and other relevant data for substance abuse disorder inpatient services.
28. Generic Drugs - Report limitations and other relevant data for generic drugs.
29. Preferred Brand Drugs - Report limitations and other relevant data for preferred brand drugs.

30. Non-Preferred Brand Drugs - Report limitations and other relevant data for non-preferred brand drugs.
31. Specialty Drugs - Report limitations and other relevant data for specialty drugs.
32. Outpatient Rehabilitation Services - Report limitations and other relevant data for outpatient rehabilitation services.
33. Habilitation Services - Report limitations and other relevant data for habilitation services.
34. Chiropractic Care - Report limitations and other relevant data for chiropractic care.
35. Durable Medical Equipment (DME) - Report limitations and other relevant data for durable medical equipment (DME).
36. Hearing Aids - Report limitations and other relevant data for hearing aids.
37. Diagnostic Test (X-Ray and Lab Work) - Report limitations and other relevant data for a diagnostic test.
38. Imaging (CT/PET Scans, MRIs) - Report limitations and other relevant data for imaging.
39. Preventive Care/Screening/Immunization - Report limitations and other relevant data for preventive care/screening/immunization.
40. Routine Foot Care - Report limitations and other relevant data for routine foot care.
41. Acupuncture - Report limitations and other relevant data for acupuncture.
42. Weight Loss Programs - Report limitations and other relevant data for weight loss programs.
43. Routine Eye Exam for Children - Report limitations and other relevant data for routine eye exam for children.
44. Eye Glasses for Children - Report limitations and other relevant data for eye glasses for children.
45. Dental Check-Up for Children - Report limitations and other relevant data for dental check—up for children.
46. Other - Report limitations and other relevant data for other benefits not previously captured.

### ***Benefit Limit Data Elements***

1. Covered? - Is this benefit covered or not covered?
2. Benefit Description - Provide benefit description if benefit is covered.
3. Quantitative Limit on Service? - If there are quantitative limits on this benefit, enter Yes
4. Limit Quantity - If there are limits on this benefit, enter the numerical limit
5. Limit Unit - If there are limits on this benefit, enter the limit unit (e.g., visits, days)
6. Other Limit Units Description - If limit unit of “other” selected, enter a description of the other limit unit
7. Minimum Stay - The minimum number of hours of hospitalization that must be covered after undergoing a certain procedure. If there is a minimum stay, list the minimum stay in hours for this benefit.
8. Exclusions - If there are exclusions for this benefit, please list/describe the exclusions.
9. Explanation - Free text field to list any notes/explanation
10. Additional Limitations or Exclusions? - If there are additional limitations or exclusions for this benefit, enter Yes and describe.

### ***Issuer and Plan Identification Data Elements***

1. Issuer Name - Full name of the State-level legal entity authorized to do business in the service areas applied for in the State.
2. HIOS Issuer ID - The unique 5-digit enumerator that identifies the company and state or territory combination in HIOS. All applicants must gain access to HIOS and get a HIOS Issuer ID before beginning the QHP Issuer Application.
3. Product Name - Legal name under which the product is marketed to consumers (HIOS Product Name if applicable).
4. HIOS Product ID - Unique ID assigned to a product.
5. Company Legal Name - The full legal name of the insurance company, service or organization which issues and underwrites health insurance policies in one or more of the 50 states or the District of Columbia. This field identifies the company with legal responsibility for all QHPs that will be associated with this application.
6. State - ID state in which benchmark is being submitted
7. Plan Name - Provide issuer-defined plan name.
8. Plan type - Select from the following choices: Health Maintenance Organization (HMO), Point-of-Service (POS), Preferred Provider Organization (PPO), Indemnity or Exclusive Provider Organization (EPO)
9. Number of Enrollees in Plan - Provide number of enrollees in the benchmark plan.
10. Supporting Document Upload - Upload of documents that will be used to support benchmark plan (e.g., SBC and SPD).

### ***Drug Data Elements***

1. National Drug Code - Unique 11-digit number that identifies the drug being included in this formulary.

### ***State Mandate Data Elements***

Please submit this information to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov).

1. State-mandated Benefit - Is the benefit mandated by the State (Yes/No)?
2. Name of Mandated Benefit - Provide the name of the mandated benefit.
3. Description of Benefit Mandates - Briefly describe the mandated benefit.
4. Market Applicability - ID the market to which the mandate applies (e.g., individual / small group).
5. State mandate enacted before December 31, 2011? - Was the benefit mandated prior to December 31, 2011 (Yes/No)?
6. Citation number - Provide legal reference.
7. Citation URL - Enter the URL (web address) for your citation.

### ***Stand-Alone Dental Data Elements***

Please submit this information to [Dental@cms.hhs.gov](mailto:Dental@cms.hhs.gov).

1. Issuer Name - Full name of the State-level legal entity authorized to do business in the service areas applied for in the State.

2. List of States - List the State or States in which the issuer intends to offer coverage in an Exchange as a stand-alone dental plan.
3. State - Identify from the list of States, the State in which the anticipated Stand-alone dental plan would be offered.
4. Individual Market Intended Participation - Indicate Y/N if you intend to offer Stand-alone dental coverage in an individual market.
5. Small Group Market Intended Participation - Indicate Y/N if you intend to offer Stand-alone dental coverage in a small group market.
6. Individual Market Intended Service Area - Provide information on the intended service area covered by the plan (e.g., county(s), partial county(s), zip code)
7. Small Group Market Intended Service Area - Provide information on the intended service area covered by the plan (e.g., county(s), partial county(s), zip code)

### ***State Benchmark Selection Data Elements***

1. Benchmark Selection Type ID - ID the type of benchmark from the following 10 options identified as:
  - a. the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market;
  - b. any of the largest three State employee health benefit plans by enrollment;
  - c. any of the largest three national FEHBP plan options by enrollment; or
  - d. the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.
2. ACA Categories Covered by Benchmark - If States select a benchmark, ID ACA categories covered by selected benchmark.
3. ACA Categories Supplemented - If States select a benchmark, ID ACA categories supplemented by another benchmark plan if necessary.
4. Alternate Approach- if a State selects as its benchmark one of the three largest small group market benchmark options, the State may choose to provide HHS with the name, benchmark selection type ID, and other necessary identifying information. If the State chooses this option, HHS will ensure coverage in all ten statutorily required categories. Please submit this information to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov).