

Supporting Statement for Essential Health Benefits Benchmark Plans

(CMS-10448/OMB Control Number: 0938-1174)

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. Beginning in 2014, all non-grandfathered health plans in the individual and small group market must cover the essential health benefits (EHB), as defined by the Secretary of Health and Human Services. The Affordable Care Act directs that the EHB reflect the scope of benefits covered by a typical employer plan and cover at least the following 10 general categories of items and services:

- (1) Ambulatory patient services.
- (2) Emergency services.
- (3) Hospitalization.
- (4) Maternity and newborn care.
- (5) Mental health and substance use disorder services, including behavioral health treatment.
- (6) Prescription drugs.
- (7) Rehabilitative and habilitative services and devices.
- (8) Laboratory services.
- (9) Preventive and wellness services and chronic disease management.
- (10) Pediatric services, including oral and vision care.

Pursuant to Section 1302 of the Affordable Care Act and Section 2707 of the Public Health Service Act, as amended by section 1201 of the Affordable Care Act, CMS released a bulletin on December 16, 2011 (EHB Bulletin)¹ describing its intent to define Essential Health Benefits (EHB) by reference to a State-specific benchmark plan. That policy was also in the rule “Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule” (EHB Final Rule) (78 FR 12834), published on February 25, 2013.¹ In order to establish an EHB benchmark plan in each State, in 2012, CMS asked States to voluntarily identify an EHB benchmark plan from the following choices that were provided in the EHB Bulletin and EHB Final Rule:

- (1) The largest health plan by enrollment in any of the three largest small group insurance products by enrollment;
- (2) Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved;
- (3) Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903; or
- (4) The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a

¹ http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf

health maintenance organization operating in the State. In those cases where a State declined to identify an EHB benchmark plan, and CMS had to therefore determine a default benchmark plan, CMS collected data from potential default benchmark plan issuers in each State based on available information concerning products offered and market position.

CMS now wishes to revise the existing information collection requests (ICRs), OMB control number 0938-1174, in order to allow States to choose a different benchmark plan for the 2017 plan year and obtain information about the chosen (or default) benchmark plan.

B. Justification

1. Need and Legal Basis

Section 1301 of the ACA requires that all non-grandfathered individual and small group health plans provide EHB, as defined by the Secretary, and subject to section 1302. Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under title I of the ACA. On June 5, 2012, HHS published “Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans” (77 FR 33133), authorizing CMS to collect data from potential default EHB-benchmark plan issuers in each State. The information collection requirement (ICR) associated with that proposed rule addressed States that selected their own benchmark plan. The proposed rule was finalized and published on July 20, 2012 at 77 FR 42658.

In accordance with 45 C.F.R. §156.100 States are permitted to select a base benchmark plan for purposes of establishing EHB in the State. If a State does not select a benchmark plan, the default base-benchmark plan is the largest plan by enrollment in the largest product by enrollment in the State’s small group market, pursuant to 45 C.F.R. §156.100(c).

Twenty-five States used a default benchmark plan because they declined to identify a plan. Of the remaining 25 States and the District of Columbia, 21 chose a plan from a small group product, two chose a State-employee plan, and three chose a commercial non-Medicaid HMO. CCIIO asked both issuers offering a default plan and States that chose their benchmark plan to provide data using a CCIIO-designed template.

Starting with the 2017 plan year, CMS intends to employ a simplified approach to selecting an EHB benchmark plan in each State that will also ensure full transparency regarding the scope and nature of State benchmark plans. Specifically, in this information collection, CMS proposes to obtain the form filing. This includes the certificate of coverage and other plan documents that the issuer filed and State approved, or if no filing or prior approval is required, that are otherwise subject to State laws and regulations relating to health insurance. It includes documents that describe covered services, exclusions, limitations, cost sharing, and all other terms and conditions of plan benefits that are provided to enrollees. Issuers already maintain records of approved form filings in electronic format, and will therefore experience the least burden possible. States that identify plans also have copies of the approved forms in electronic format. Both parties retain these documents in virtual perpetuity based on industry and regulatory requirements. The approach proposed here, therefore, has the effect of reducing the reporting burden since the documents sought already exist independently of CMS reporting purposes, and are therefore not created for the purpose of reporting to CMS. Additionally,

this information collection does not propose to use a collection instrument, since the documents are already available in PDF or word processing format. Affected entities would instead submit the documents to an email box.

2. Information Uses

The benchmark plan information is used by CMS, issuers, and consumers to establish the benefits covered by benchmark plans in each State. This allows issuers seeking to offer coverage in the individual and small group markets to design benefits that meet EHB requirements. The information is used to inform CMS and States, as well as Exchanges, in their efforts to ensure plans are meeting EHB requirements for qualified health plan (QHP) certification and EHB compliance.

3. Use of Information Technology

CMS will obtain the final form filing that was submitted to the State regulator and any other information the State or issuer wishes to provide for a full picture of covered benefits, limits and exclusions, as noted above. For example, the State or issuer will provide riders, amendments, insert pages, corrections, or other documents associated with the form filing itself.

4. Duplication of Efforts

There is no duplication of efforts. Benchmark plan information will only be collected through this method.

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 annually.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

As required by the Paperwork Reduction Act of 1995 (44 U.S.C.2506 (c)(2)(A)), CMS published notices in the Federal Register requesting a 60-day public comment process on the proposed modification of the information collection requirements in the proposed rule for the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P). The public did not submit comments for the 60-day comment period of this ICR. CMS is requesting a 30-day public comment period.

In the Draft HHS Notice of Benefit and Payment Parameters for 2016 (CMS-9944-P), published November 26, 2014, CMS proposed and solicited comment on 45 C.F.R. §156.120 (79 CFR 70718)

that would require a State that selected an EHB-benchmark plan, or an issuer that offered a default EHB-benchmark plan, to provide benchmark plan data to CMS.

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.

11. Sensitive Questions

No sensitive questions are asked in this data collection.

12. Burden Estimates (Hours & Wages)

The following sections of this document contain estimates of the burden imposed by the associated information collection requirements (ICRs); however, not all of these estimates are subject to the PRA for the reasons noted. Salaries for the positions cited were mainly taken from the Bureau of Labor Statistics (BLS) Web site (http://www.bls.gov/oco/ooh_index.htm).²

Burden on Issuers and States

We estimate that it will take 1.5 hours for a health insurance issuer or State to meet this reporting requirement, which should consist of no more than electronic transmission of a single data file consisting of the form filed with the State regulator that constitutes the final form filing that describe the benefits, limits, and exclusions under the plan that is being chosen as the State benchmark plan for the 2017 benefit year.

Based on EHB benchmark plan development by States choosing to designate a plan in 2011, we estimate 25 issuers will have to report in lieu of the State, and that 25 States plus the District of Columbia will report to CMS directly. Given that we only need a single data file developed by the relevant issuer that offers the plan, the total burden is estimated to be 76.5 hours, across the 51 reporting entities. We anticipate the reporting requirement will require a health policy analyst 1.5 hours annually to identify and submit the responsive records to CMS (at \$49.35 per hour), for a total cost of \$74.03 a year per reporting entity. The estimated 1.5 hours also includes the time required for States to choose a benchmark plan and the time required for issuers to identify the largest plan by enrollment in the three largest small group insurance products. States that select a benchmark plan will need to submit the form filing. 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.

² <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf>

The total number of respondents will be 51, for a total burden of 76.5. Below is the estimate of the burden imposed on a single health insurance issuer or a single State subject to the reporting requirements of this rule. OMB approvals are issued for three years; therefore, the aggregate burden for three years will be \$11,326.59 per respondent. However, we do not anticipate requiring annual collections.

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours per Respondent	Total Burden Costs per Respondent	Total Burden Costs (All Respondents)
Issuer or State Health Policy Analyst	51	\$49.35	1.5	\$74.03	\$3,775.28
Annualized three year burden per respondent			230	\$222.09	\$11,326.59

Burden on Stand Alone Dental Plan Issuers

CMS is requesting that issuers that intend to offer stand-alone dental plans in any Exchange 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 175 issuers will respond to this data collection. Therefore, we anticipate that the reporting requirement will require a health policy analyst one half-hour annually to identify and submit the responsive records to CMS (at \$49.35 per hour), for a total cost of \$24.68 a year per reporting entity. The total number of respondents will be 175, for a total burden of \$4,294.32. OMB approvals are issued for three years; therefore, the aggregate burden for three years will be \$12,957.00 per respondent.

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

Labor Category	Number of Respondents	Hourly Labor Costs (Hourly rate + 35% Fringe benefits)	Burden Hours	Total Burden Cost per Respondent	Total Burden Costs (All Respondents)
Issuer or State Health Policy Analyst	175	\$49.35	0.5	\$24.68	\$4,319.00
Annualized three year burden per respondent			1.5	74.04	\$12,957.00

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

The burden hours have decreased from 642 to 318. CMS is reducing burden on issuers and states by eliminating the submission of reporting instruments. The Department is proposing to employ a simplified approach to selecting an EHB benchmark plan beginning in 2017. The information being requested already exists independently of CMS reporting requirements and therefore, the collection of information has a minimal impact the public. Further, once the information is compiled CMS is asking to receive the requested files via email. The existing ICR assumes burden for 153 respondents (issuers and states). The number of respondents is being reduced from 158 to 51 respondents. The burden related to Dental Plans has risen due to the increase in the number of issuers, from 20 issuers to 175 issuers.

17. Expiration Date

CCIIO has no objections to displaying the expiration date.