Supporting Statement for Essential Health Benefits Benchmark Plans

(CMS-10448/OMB control number: 0938-1174)

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA; P.L. 111-148) was signed into law, and on March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) was signed into law. The two laws implement various health insurance policies, including the essential health benefits (EHB). Beginning in 2014, all non-grandfathered health plans in the individual and small group market must cover the EHB, as defined by the Secretary of Health and Human Services. The PPACA 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 PPACA and Section 2707 of the Public Health Service Act, as amended by section 1201 of the PPACA, CMS released a bulletin on December 16, 2011 (EHB Bulletin)[1] describing its intent to define EHB by reference to a State-specific benchmark plan. That policy was finalized 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.[2] In order to establish an EHB-benchmark plan in each State, in 2012, CMS asked States to voluntarily identify an EHB-benchmark plan from 10 options that were provided in the EHB Bulletin. The EHB Final Rule applied those benchmark plans starting in the 2014 plan year as a transitional policy. Then, in 2015, CMS asked States to voluntarily identify an EHB-benchmark plan from those 10 options for a second time based on 2014 plans that would apply beginning in the 2017 plan year.

In the final rule entitled the *HHS Notice of Benefit and Payment Parameters for 2019* (2019 Final Payment Notice; CMS-9930-F),[3] we changed the State's EHB-benchmark plan selection process beginning for 2020 plan year. For plan years beginning on or after January 1, 2020, subject to §156.111(b), (c), (d) and (e), a State may change its EHB-benchmark plan by:

[1] http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf
[2] https://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf
[3] A copy of the final rule is posted on CCIIIO's website at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html.

(1) Selecting the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110;

(2) Replacing one or more categories of EHBs under §156.110(a) under its EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under §156.100 and §156.110; or

(3) Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

To reflect this change, CMS is revising the existing information collection requirements in order to reflect the policy changes to obtain information for when a State is changing its EHB-benchmark plan selection. We are also including estimates to the stand-alone dental plan (SADP) voluntary reporting information collection that is also covered in the OMB control number noted above.

B. Justification

1. Need and Legal Basis

Section 1302 of the PPACA requires that all non-grandfathered individual and small group health plans provide EHB, as defined by the Secretary. Section 1321(a) requires HHS to issue regulations setting standards for meeting the requirements under title I of the PPACA. 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), initially authorizing CMS to collect data from potential default EHB-benchmark plan issuers in each State. The ICR associated with that proposed rule addressed States' selection of their own benchmark plan. The proposed rule was finalized and published on July 20, 2012 at 77 FR 42658. A revised ICR was published with the *HHS Notice of Benefit and Payment Parameters for 2016* (CMS-9944-P and CMS-9937-F) and the ICR was finalized on August 28, 2015. As part of the 2019 Proposed Payment Notice, we proposed to revise this ICR requesting a 60-day public comment process, which also proposed to add one new EHB section to the regulation at §156.111. We are finalizing new regulations at §156.111 for a State's EHB-benchmark plan and are now requesting a 30-day public comment process as part of the 2019 Final Payment Notice.

In accordance with §156.111(e), for plan years beginning on or after January 1, 2019, a State changing its EHB-benchmark plan using one of the options at §156.111(a) must submit documents specified by HHS in a format and manner by a date determined by HHS. These required documents include:

(1) A document confirming that the State's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c), including information on which selection option under proposed §156.111(a) the State is using, and whether the State is using another State's EHB-benchmark plan;

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies that affirms:

(i) That the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i); and

(ii) That the new EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in §156.111(b)(2)(ii);

(3) The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in §156.111(a)(3), a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan.

Unlike the previous ICR, a response is not needed for all States. Only States choosing to modify the State's EHB-benchmark plan would need to respond to this ICR. However, the number and types of documents needed in this ICR differ from the previous ICR. This information collection uses collection instruments in Appendices A, B, C, D, E and G in addition to requiring the State to submit the same documentation in the previous ICR.[4] We provide collection instruments for certain documents in this ICR and for other documents in this ICR, we do not have collection instruments. These collection instructions have been updated in accordance with the Final 2019 Payment Notice and in response to comments received. For documents without collection instruments, the State will submit these documents in a PDF or Word format. States will submit these documents electronically. We may use a web-based tool to collect these documents with e-mail as back up option, and we believe that the burden would be the same for collecting all of these documents in a web tool or via email.

2. Information Uses

There are no other ICRs that obtain the information in this ICR or cover this requirement. The benchmark plan information in this ICR is used by issuers and CMS to establish the benefits covered by benchmark plans in each State as EHB. This allows issuers seeking to offer coverage in the individual and small group markets to design benefits that meet EHB requirements and each State's EHB-benchmark plan determines EHB for the purposes of the availability of premium tax credits and cost-sharing reductions for enrollees in the State.[5] This information collection also includes issuer reporting on their intent to offer SADPs. This 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. In accordance with the Final 2019 Payment

[4] Appendix E is only for information purposes.

[5] The definition of EHB also has an impact on the annual limitation on cost sharing at section 1302(c) of the PPACA (which is incorporated into section 2707(b) of the PHS Act) and the prohibition of annual and lifetime dollar limits at section 2711of the PHS Act, as added by the PPACA.

Notice, documents collected in this information collected will be posted on the CCIIO webpage (see Section 3 below).

3. Use of Information Technology

The documents need to be submitted electronically. Specifically, we may use a web-based tool with e-mail as back up option to collect the documents under this ICR. As described in the 2019 Payment Notice, the information in this information collection will be posted on Center for Consumer Information and Insurance Oversight (CCIIO) webpage on the essential health benefits.[6]

4. Duplication of Efforts

There is no duplication of efforts. States' EHB-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 plan data collection will occur annually. The respondents will likely be different respondents each year. If the collection was less frequently, it would decrease the flexibility for States on when they could choose to make changes to their EHB-benchmark plans.

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 this ICR with the 2019 Proposed Payment Notice on November 2, 2017 (82 FR 51052), requesting a 60-day public comment process. With the 2019 Final Payment Notice, CMS is publishing this notice in the Federal Register requesting a 30-day public comment process. This notice amends the ICR for establishing a State's EHB-benchmark plan. The Final 2019 Payment Notice also finalizes the new policies at §156.111 that change the State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 and the collection of data to select EHB-benchmark plan for plan years beginning on or after the January 1, 2020.

[6] The current CCIIO webpage for EHB benchmark plans is available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

CMS received a total of five (5) comments in response to the 60-day comment period. Comments have been addressed in Appendix F.

9. Payments/Gifts to Respondents

No payments or gifts were made to any respondents.

10. Confidentiality

CMS will post the documents collected through this data collection in a similar manner and format to the documents CMS currently provides on States' EHB-benchmark plans and in accordance with the 2019 Final Payment Notice.

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 incorporated ICRs, but this burden estimate does not include estimate for a State to conduct reasonable public notice and an opportunity for public comment as finalized at §156.111(c). Average labor costs (including 100 percent fringe benefits) used to estimate the costs are calculated using data available from the May 2016 National Industry-Specific Occupational Employment and Wage Estimates (Bureau of Labor Statistics (BLS) (https://www.bls.gov/oes/current/naics4_999200.htm#11-0000).

Burden on States

Under the previous benchmark plan selection policy, 29 States selected one of the 10 base benchmark plan options and 22 States defaulted and that policy did not allow for States to make an annual selection. The revised regulation allows States to modify their EHB-benchmark plans annually, but would not require them to respond to this ICR for any year for which they did not change their EHB-benchmark plans. As such, for purposes of this regulation, we estimate that 10 States would choose to make a change to their EHB-benchmark plans in any given year (for a total of 30 States over 3 years within the authorization of this ICR) and would respond to this ICR. The following details the burden attached to part of this information collection.

First, to select a new EHB-benchmark plan, we require at §156.111(e)(1) that the State provide confirmation that the State's EHB-benchmark plan selection complies with certain requirements, including those under §156.111(a), (b), and (c). To collect this information, the State submits the associated document in Appendix A. To complete this requirement, we estimate that a financial examiner would require 4 hours (at a rate of $66.04 per hour) to fill out, review, and transmit a complete and accurate document. We estimate that it would cost each State approximately $264 to meet this reporting requirement, with a total annual burden for all 10 States of 40 hours and an associated total cost of $2,642.

Second, we require at §156.111(e)(2) that the State submit an actuarial certification and associated actuarial report of the methods and assumptions when selecting options under §156.111(a). Specifically, we are finalizing at §156.111(b)(2)(i) and (ii) that a State's EHB-benchmark plan must provide benefits at least equal in scope of benefits to what is provided under a typical employer plan and that the State's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans. The actuarial certification that is being collected under this ICR is required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This estimate includes complying with all applicable ASOPs (including ASOP 41 on actuarial communications). For example, ASOP 41 on actuarial communications includes disclosure requirements, including those that apply to the disclosure of information on the methods and assumptions being used for the actuarial certification and report. The actuarial certification for this requirement is provided in a template in Appendix B and includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary is required to be a Member of the American Academy of Actuaries.

We estimate that an actuary, who is a member of the American Academy of Actuaries, requires 18 hours (at a rate of $80.82 per hour) on average for §156.111(e)(2). This includes the certification and associated actuarial report from an actuary to affirm, in accordance with generally accepted actuarial principles and methodologies that the State's EHB-benchmark plan must provide a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at §156.110(a), the scope of benefits provided under a typical employer plan, as defined at §156.110(b)(2)(i) and that the State's EHB-benchmark plan definition does not exceed the generosity of the most generous among the set of comparison plans. We are also finalizing a document entitled Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b) (2)(i) and (ii) that provides an example of a method an actuary could use to develop the actuarial certification and associated report at §156.111(e)(2) for both the typical employer plan benefit and comparison plan standards.

For these calculations, the actuary needs to conduct the appropriate calculations to create and review an actuarial certification and associated actuarial report, including minimal time required for recordkeeping. The precise level of effort for the actuarial certification and associated actuarial report under §156.111(e)(2) will likely vary depending on the State's approach to its EHB-benchmark plan and this certification requirement. For example, as described in the Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection in Accordance with 45 CFR 156.111(b)(2)(i) and (ii), to reduce the burden of these standards, the actuary may want to consider using the same plan for both the generosity and the typicality tests, provided that the plan meets the standards at both §156.111(b)(2)(i) and (ii). For example, the actuary may only need to do one plan comparison for the purposes of both of these certification requirements. Specifically, the actuary could use the same plan, such as the State's EHB-benchmark plan used for the 2017 plan year. That plan would, by definition, be a "Comparison Plan." Because the State's EHB-benchmark plan used for the 2017 plan year would simply be one of the State's base-benchmark plans, supplemented as necessary under §156.110, that plan also could be used for purposes of determining typicality, as a

proposed State EHB-benchmark plan that was equal in scope of benefits to the State's EHB-benchmark plan used for the 2017 plan year within each EHB category at §156.110(a) would be equal to or greater in scope of benefits within each EHB category at §156.110(a) than the base-benchmark plan underlying the EHB-benchmark plan used for the 2017 plan year, to the extent of the required supplementation.

We increased the estimated burden hours from 16 hours to 18 hours for the actuary to complete the actuarial certification and associated report in recognition of the extension of the generosity standard and in recognition that the definition of typical employer plan may require the actuary to determine whether the typical employer plan meets MV requirements. We are also increasing the estimated number of States that need to respond to this section of the ICR from 7 to 10 since the typical employer plan standard and the generosity standard applies to all State's EHB-benchmark plan options at §156.111(a). For the actuarial certification, we provide the collection instrument in Appendix B. We estimate that a financial examiner will require 1 hour (at a rate of $66.04 per hour) to review, combine, and electronically transmit these documents to HHS, as part of a State's EHB-benchmark plan submission. We estimate that each State will incur a burden of 19 hours with an associated cost of $1,520.80 with a total annual burden for 10 States of 190 hours at associated total cost of $15,208.

Third, we require at §156.111(e)(3) each State to submit its new EHB-benchmark plan documents. The level of effort associated with this requirement could depend on the State's selection of the EHB-benchmark plan options under the regulation at §156.111(a). However, for the purposes of this estimate, we estimate that it would require a financial examiner (at a rate of $66.04 per hour) 12 hours on average to create, review, and electronically transmit the State's EHB-benchmark plan document that accurately reflects the benefits and limitations, including medical management requirements and a schedule of benefits, resulting in a burden of 12 hours and an associated cost of $792, with a total annual burden for all 10 states of 120 hours and an associated cost of $7,925. The burden for producing these documents is significantly higher than previous estimates because the previous data collection generally only required the State (or issuer) to transmit the selected benchmark plan document. In contrast, in some cases, §156.111(a) may result in the State needing to create a completely new document or significantly modify the current document to represent the plan document. Additionally, this estimate of 12 hours also includes the burden necessary for a State selecting the option at §156.111(e)(3) where the State is required to submit a formulary drug list for the State's EHB-benchmark plan in a format and manner specified by HHS. Specifically, the burden for the State selecting this option is also likely vary as the State could use an existing formulary drug list or create its own formulary drug list separately for this purpose. To collect the formulary drug list, the State is required to use the template provided by HHS and must submit the formulary drug list as a list of RxNorm Concept Unique Identifiers (RxCUIs). This template is incorporated in Appendix D.

Lastly, §156.111(e)(4) requires the State to submit the documentation necessary to operationalize the State's EHB-benchmark plan definition. This reporting requirement includes the EHB summary file that is currently posted on CCIIO's website and is used as part of the QHP certification process and is integrated into HHS's IT Build systems that feeds into the data that is displayed on HealthCare.gov.[7] This document format is incorporated as a template in Appendix C. While this document is not a new document, the burden associated with this document is new for States. We estimate that it would

[7] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

require a financial examiner 12 hours, on average, (at a rate of $66.04 per hour) to create, review, and electronically submit a complete and accurate document to HHS resulting in a burden of 12 hours and an associated cost of $792, with a total annual burden for all 10 states of 120 hours and an associated cost of $7,925.

We estimate that the total number of respondents would be 10 per year, for a total yearly burden of 470 hours and an associated cost of $33,699 to meet these reporting requirements. Below is the estimate of the burden imposed on a State subject to the reporting requirements of this final rule.

Table 1 – Burden for Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§156.111(e)(1)	10*	10	4	40	$2,641.60	$2,641.60
§156.111(e)(2)	10*	10	19	190	$15,208.00	$15,208.00
§156.111(e)(3)	10*	10	12	120	$7,924.80	$7,924.80
§156.111(e)(4)	10*	10	12	120	$7,924.80	$7,924.80
Total	10	40	47	470	$33,699.20	$33,699.20

* Denote the same entities. For purposes of calculating the total, value is used only once.

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 market research analyst one half-hour annually to identify and submit the responsive records to CMS (at $67.90 per hour), for a total cost of $33.95 a year per reporting entity. The total number of respondents will be 175, for a total burden of $5,941.

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

Regulation Section(s)	Respondents	Responses	Burden per Response (hours)	Labor Cost of Reporting ($)	Total Cost ($)
Issuer or State Market research analyst	175	175	0.5	$67.90[8]	$5,941.25
Totals	175	175	87.5	$67.90[9]	$5,941.25

Burden on States for Substitution

Lastly, as part of the update to this OMB control number: 0938-1174, we are adding an information collection request to this ICR to account for the finalized policy at §156.115(b)(2)(ii) that allows the State the option to notify HHS that the State will allow substitution between EHB categories of benefits, beginning with the 2020 plan year. Specifically, §156.115(b)(2)(ii) will allow issuers to substitute benefits only when the State in which the plan will be offered permits such substitution and notifies HHS of its decision to allow substitution between categories. We anticipate that States will notify HHS through the same means the States will notify HHS of an updated EHB-benchmark plan selection under §156.111 and as reflected in Appendix G, we intend to provide a preformatted response for States to use to provide the notification to HHS. To provide notification under §156.115(b)(2)(ii), we estimate that it will require a financial examiner 1/2 hour, on average, (at a rate of $66.04 per hour) to review and electronically submit a notification to HHS. Furthermore, we estimate that at most 5 States will want to allow the flexibility for their issuers to substitute between categories under §156.115(b)(2)(ii). While this aspect of the ICR is not subject to the PRA because we estimate that no more than 5 States will be affected annually, we nonetheless provide a total annual burden estimate for §156.115(b)(2)(ii), which is 2.5 hours and a total associated cost of $165.

[8] Hourly rate of $33.95 for market research analyst https://www.bls.gov/oes/current/oes131161.htm
[9] Hourly rate of $33.95 for market research analyst https://www.bls.gov/oes/current/oes131161.htm

Labor Category	Respondents	Responses	Burden per Response (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§156.115(b)(2)(ii)	5	5	0.5	$165.10	$165.10
Totals	5	5	2.5	$165.10	$165.10

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

In response to 60-day comments (see Appendix F) and to align with the policy finalized in Final 2019 Payment Notice, certain modifications were made to the collection instruments in the Appendices. Burden estimates associated with §156.112(e)(2) increased from 16 hours to 18 hours for the actuary to complete the actuarial certification and associated report. The change was made in recognition of the extension of the generosity standard and in recognition that the definition of typical employer plan may require the actuary to determine whether the typical employer plan meets minimum value requirements as finalized in the Final 2019 Payment Notice. Lastly, the estimated number of States that need to respond to §156.112(e)(2) increased from 7 to 10 due to revisions in §156.111(b)(2)(i) and (ii).

The overall burden hours increased by 395 hours (from 165 hours to 560 hours). However, the existing ICR assumed burden for 226 respondents and this ICR estimates an overall decrease to 190 respondents per year due to certain issuers and States no longer being required to respond to the information collection. The total costs for §156.111(e) per year is estimated to increase $25,605.20 (from $8,094 to $33,699.20) and the stand-alone dental plan data collection is estimated as $5,941 total costs per a year. The burden related to SADP issuers has risen due to increased fringe and overhead costs. The burden for §156.115(b)(2)(ii) of $165.10 is new to this ICR.

16. Publication/Tabulation Dates

Yes, in accordance with the 2019 Payment Notice, documents covered under this information collection will be posted on the CCIIO website at some point after the annual deadline for State submission for its EHB-benchmark plan.[10]

17. Expiration Date

The expiration date and OMB control number will be displayed on the first page of each instrument (top, right-hand corner).

[10] https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.