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 proposed rule entitled the *HHS Notice of Benefit and Payment Parameters for 2019* (2019 Proposed Payment Notice; CMS-9930-P),[3] we propose to change the State's EHB-benchmark plan selection process starting in 2019. We propose that for plan years beginning on or after January 1, 2019, subject to proposed §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 proposed 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) of this subpart 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, provided that the new EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans, including: the State's EHB-benchmark plan used for the 2017 plan year, and any of the State's base-benchmark plan options used for the 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110.

To reflect this proposed change, CMS now wishes to revise the existing information collection requests (ICRs), OMB control number 0938-1174, in order to reflect the proposed policy 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 1301 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 information collection requirement (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. We propose to revise this ICR requesting a 60-day public comment process as part of the 2019 Proposed Payment Notice, which also proposes to add one new EHB sections to the regulation at §156.111.

In accordance with the proposals included in §156.111(e), for plan years beginning on or after January 1, 2019, a State changing its EHB-benchmark plan using one of the proposed options at §156.111(a) must submit documents specified by HHS in a format and manner by a date determined by HHS. These documents would be required to 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) If the State is selecting its EHB-benchmark plan using the options proposed at §§156.111 (a)(2) or (a)(3), 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: that the State's EHB-benchmark plan definition is equal in scope of benefits provided under a typical employer plan; and if the State is selecting its EHB-benchmark plan using the option proposed at §156.111(a)(3) of this section, that the new EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed at §156.111(a)(3)(i) and (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 option proposed at §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 the proposed ICR differ from the previous ICR. This information collection proposes to use collection instruments that are attached to the proposed PRA in addition to requiring the State to submit the same documentation in the previous ICR. We propose collections instruments for certain documents in this ICR and for other documents in this ICR, we do not have collection instruments. For these documents without collection instruments, the State could submit these documents in a PDF or word processing format. States would submit these documents electronically. We are considering using 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 CMS, issuers, and consumers 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.[4] This information collection also covered stand-alone dental plans. 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. Some documents collected in this information collected will be posted (see Section 3 below).

3. Use of Information Technology

[4] 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.

The documents need to be submitted electronically. Specifically, we are considering using a web based tool with e-mail as back up option. Much of the information in this information collection will be posted on Center for Consumer Information and Insurance Oversight (CCIIO) webpage on the essential health benefits, similar to what is currently available on CCIIO's webpage.[5]

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 is publishing this notice in the Federal Register requesting a 60-day public comment process in the 2019 Proposed Payment Notice. This notice proposes to amend the ICR for establishing a State's EHB-benchmark plan. This proposed rule is also soliciting comments on proposals at §156.111 that proposes to change the State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2019 and the collection of data to define essential health benefits for plan years beginning on or after the January 1, 2019.

No additional outside consultation was sought.

9. Payments/Gifts to Respondents

No payments or gifts were made to any respondents.

10. Confidentiality

CMS intends to post some of the proposed documents collected through this data collection in a similar manner and format to the previous documents that CMS currently provides on States' EHB-

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

benchmark plans. This includes the plan documents under proposed §156.111(e)(3) and other documentation necessary to operationalize the State's EHB-benchmark plan definition under proposed §156.111(e)(4) that include the State's EHB summary chart. CMS is also soliciting comments on whether to publish one of the new documents that is being collected in this data collection at §156.111(e)(1).

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 proposed at proposed §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 proposed regulation would allow 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 proposed 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.

The proposals at §156.111(e)(1) would require the State to provide a document confirming that the State's EHB-benchmark plan selection definition complies with certain requirements, including those under proposed §156.111(a), (b), and (c). To collect this information, the State would be expected to submit 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.

The proposals in §156.111(e)(2) would further require the State to submit an actuarial certification and associated actuarial report of the methods and assumptions when selecting proposed options under §156.111(a)(2) and (3). Specifically, the actuarial certification that is being collected under this ICR would be required to include an actuarial report that complies with generally accepted actuarial principles and methodologies. This would include complying with all applicable Actuarial Standards of Practice (ASOPs) (including but not limited to ASOP 41 on actuarial communications). For example, ASOP 41 on actuarial communications includes complying with required 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 proposed requirement is provided in a template and includes an attestation that the standard actuarial practices have been followed or that exceptions have been noted. The signing actuary would be required to be a Member of the American Academy of Actuaries. We are also seeking comment on a draft document entitled *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)* that would provide an example of a method an actuary could use to develop the actuarial certification and report.[6]

We estimate that an actuary, who is a member of the American Academy of Actuaries, would require 16 hours (at a rate of $80.82 per hour) on average for §156.111(e)(2). This would include 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 definition is equal in scope of benefits provided under a typical employer plan. Additionally, this estimate of 16 hours would also apply if the State is selecting its EHB-benchmark plan using the option proposed at §156.111(a)(3). The option proposed at §156.111(a)(3) would also require the actuary to affirm that the State's selected EHB-benchmark plan does not exceed the generosity of the most generous among a set of comparison plans proposed at §156.111(a)(3), including the State's EHB-benchmark plan used for the 2017 plan year and any of the State's base-benchmark plan options used for 2017 plan year described in §156.100(a)(1), supplemented as necessary under §156.110. For these calculations, the actuary would need 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 actuary certification and associated actuarial report under §156.111(e)(2) is likely to vary depending on the State's approach to its EHB-benchmark plan and this certification requirement. For example, the State may only need to do one plan comparison for the purposes of both of these proposed certification requirements. Specifically, the State could use the same plan, such as the State's EHB-benchmark plan used for 2017 plan year, to determine that the new State's EHB-benchmark plan is equal in scope of benefits provided under a typical employer plan. The State could also use those findings to determine that because the new State EHB-benchmark plan is equal in scope of benefits to the State's EHB-benchmark plan used for the 2017 plan year, the ne State's EHB-benchmark plan does not exceed the generosity of the most generous of a set of comparison plans. For the actuarial certification, we provide the template for that document in Appendix B. We estimate that a financial examiner would require one 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. Because this section of the proposed regulation would only apply to options 2 and 3 under proposed §156.111(a)(2) and (3), we are estimating that only two thirds of States (7 of the 10 States) would need to complete and submit this proposed documentation requirement. Therefore, we estimate that each State would incur a burden of 17 hours with an associated cost of $1,359, with a total annual burden for 7 states of 119 hours at associated total cost of $9,514. We seek comment on this estimate.

The proposals at §156.111(e)(3) would further require each State to submit its new EHB-benchmark plan documents. The level of effort associated with this requirement could depend on the State's

[6] The *Draft Example of an Acceptable Methodology for Comparing Benefits of a State's EHB-benchmark Plan Selection to Benefits of a Typical Employer Plan As Proposed under the HHS Notice of Benefit and Payment Parameters for 2019 (CMS-9930-P)* is available on CCIIO's Regulation and Guidance webpage at https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html.

selection of the EHB-benchmark plan options under the proposed 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, the proposed §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 propose §156.111(e)(3) where the State would also be 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 would 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 would be 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 A.

Lastly, the proposals at §156.111(e)(4) would require 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 A. While this document would not be a new document, the burden associated with this document would be new for States. We estimate that it would 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 399 hours and an associated cost of $28,005 to meet these reporting requirements. Below is the estimate of the burden imposed on a State subject to the reporting requirements of this proposed rule. We solicit comments on these proposed estimates.

Proposed Annual Recordkeeping and Reporting Requirements

Regulation Section(s)	OMB control number	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§156.112(a)(1)	0938-1174	10*	10	4	40	$2,641.60	$2,641.60

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

Regulation Section(s)	OMB control number	Respondents	Responses	Burden per Response (hours)	Total Annual Burden (hours)	Labor Cost of Reporting ($)	Total Cost ($)
§156.112(a)(2)	0938-1174	7*	7	17	119	$9,514.12	$9,514.12
§156.112(a)(3)	0938-1174	10*	10	12	120	$7,924.80	$7,924.80
§156.112(a)(4)	0938-1174	10*	10	12	120	$7,924.80	$7,924.80
Total	--	10	37	40	399	$28,005.32	$28,005.32

* 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.

Labor Category	Number of Respondents	Hourly Labor Costs	Burden Hours	Total Burden Cost per Respondent	Total Burden Costs (All Respondents)
Issuer or State Market research analyst	175	$67.90[8]	0.5	$33.95	$5,941

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

Labor Category	Number of Respondents	Hourly Labor Costs	Burden Hours	Total Burden Cost per Respondent	Total Burden Costs (All Respondents)
Annual burden hours			88		

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 total burden hours have increased by 322 hours (from 165 hours to 487 hours). However, the existing ICR assumes burden for 226 respondents and the proposed ICR estimates 185 respondents per year due to certain issuers and States no longer being required to respond to the information collection. The total costs for proposed §156.111(e) per year is estimated to increase by $19,911 from $8,094 to $28,005 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 while the number of participating issuers remains the same at 175 issuers.

16. Publication/Tabulation Dates

Yes, certain documents covered under this information collection will be posted on the Center for Consumer Information and Insurance Oversight's (CCIIO) website at some point after the annual deadline for State submission for its EHB-benchmark plan.

17. Expiration Date

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