Appendix D Insurance Issuer and Product Level Data

Issuer Requirements for Individual Market or Small Group Market

This section covers requests for information from issuers with offerings of health insurance coverage on an individual or small group basis. The Patient Protection and Affordable Care Act (PPACA), Section 1103(a)(2) "Connecting to Affordable Coverage" (as modified by section 10102) requires the Secretary to "provide ways for residents of, and small businesses in, any state to receive information regarding their health insurance options, including "health insurance coverage offered by health insurance issuers" under sub-section (A).

As a result the Secretary is requiring that each issuer report on individual and small group health insurance plans, coverage options that combines both the product (package of benefits) and a specific cost sharing option for that product.

While some of the required information is already gathered by the states, most states do not require detailed specification of benefits and pricing necessary for informed consumer decisions. The variance between state collection standards also makes aggregating the data in a single place for comparisons impossible. As a result, the Secretary is requiring a new data submission.

As this information is already known to and compiled by issuers, minimal difficulties are anticipated in meeting these reporting requirements. The primary burden will likely be transforming the data into a standardized reporting format. Nevertheless, the emergence of a standard for reporting will allow for commonalities to emerge which will reduce the burden of meeting current data requirements utilizing a variety of standards from the states and federal government.

The following criteria were used in selecting reporting requirements:

1) Utility for citizen discovery and differentiation of available health insurance options in their area of residence.
2) Minimal administrative burden on issuers;
3) Legislative and regulatory authority;
4) Rapid availability of valid, reliable data elements.

To reduce the ultimate burden on issuers, the Secretary will undertake to contract with a vendor who currently has significant coverage of information in these two markets. Initial data requirements will thus take place in two stages. First, issuers and States will be required to provide minimal information used to define the universe of plans in an area. This data will also be used to verify that all issuers are ultimately represented, and that information gathered is correct. This information will be required by May 21, 2010 in order to define from whom additional information is required.

May 21 and Subsequent Data Collection:

Issuer Corporate and Contact Information

One requirement for connecting citizens to affordable coverage is the name of the issuers from whom they can purchase coverage and the contact information of those parties.

A. Issuer Name: Issuer name shall be provided as the legal name of the entity registered to provide the plan within the coverage area.
B. IRS Federal Employer Identification Number (EIN): Issuers are required to provide the employer identification number under which they pay taxes to the IRS. This element is obtained solely to allow for unique identification of the entities, and required verification of information.
C. NAIC Company Code Number: Issuers are required to provide the NAIC Company Code number if they have one.
D. Issuer Address: The Issuer Address is the official street address used to receive information requests from the public via the US Postal Service or commercial postal firms.
E. Rating: The issuer should report whether or not they have been rated by an independent company, the source of that rating, and what the rating is.
F. Customer Service Phone Number – Toll-Free: This element should be provided if a toll free number is available for specific consumer requests for plan information.
G. Customer Service Phone Number – Local: This element represents a local phone number within the area of coverage retained by the issuer for receiving requests for information from the public.
H. Customer Service Phone Number – TTY: This element represents a phone number for receiving information from the deaf.
I. Website address – link to Issuer: The URL of the issuer which contains general information on the company.
J. Contact Information – Contact names, phone numbers and email addresses will be collected for a primary and backup contact for individual and small group markets allowing for different information to be entered for data submission and data validation contacts.

Geographic coverage information

In order to be able to display appropriate plan information to potential consumers, we need to gather the geographic information on the product offering area. Zip codes are the most appropriate level of collection, as plans may often be offered in areas that cross county lines or cover only part of a county.

A. State: The state of the product offering
B. Offering Area: The set of zip codes which constitute the area in which the issuer is offering the product for sale.

Product administrative information

While future implementations of Section 1103 of the PPACA may ask for additional administrative information necessary for consumers to be able to evaluate plans, in order to minimize the burden on information providers we will not focus on those details for this data request. Other elements that will not be covered in this request are to be collected under 2718 of the PHSA (specifically the medical loss ratio in 2011), but are not being requested at this time. We do require enrollment. Our intent at this time is to gather a minimum amount of information necessary to prioritize the presentation of information and coordinate plan and product level data.

A. Product enrollment: Number of individual (or family) enrollments for the most recent completed product year.
B. Number of applications received: The number of applications which were submitted for enrollment under the product during the reference quarter according to the schedule specified below.
C. Number applications denied for product enrollment (individual market only): In order to inform consumers about the relative risk that they will be unable to obtain this insurance, issuers will report the number of applications which were denied for enrollment or pended for healthcare intervention (for example until after surgery) or not accepted at terms applied for but offered a counteroffer (for example offered a policy under a much higher deductible) during the reference quarter.
D. Number up-rated offers: Actual premiums may vary widely for most products. Issuers are required to report the number of offers issued for a product which were "up-rated," such that the under-writing process has resulted in a premium quote higher than the base rate for the reference quarter.

Reference Quarters for Reporting on Applications
September data collection – First quarter of current year (January 1 to March 31, 2010)
December refresh – Second quarter of current year (April 1 to June 30, 2010)
March refresh – Third quarter of prior year (July 1 to September 30, 2010)
June Refresh – Fourth quarter of prior year (October 1 to December 31, 2010)

Product contact and detail information

This section references the specific fields necessary to identify the product, and for consumers to obtain specific plan level information.

A. Product name: The name under which the product is marketed to consumers. It should be substantively similar to product name reported in Part II Section 1(a) of IRS Form 5500.
B. Product number: In cases where a product has an assigned three digit product number equivalent to the product number/Enrollment Code used for filing IRS Form 5500, that information shall be provided.
C. Market type: In order to appropriately direct consumers, issuers will indicate whether the product specified is an individual or small group offering.
D. Product type (e.g., indemnity/HMO/PPO): Product type is the most common means of identifying general limits on provision of services. To provide the consumer with a basic understanding of the plan, it is essential to gather the type of product. These types will be defined in correspondence with the "health care plans and systems" defined by the Interdepartmental Committee on Employment-based Health Insurance Surveys (Indemnity Plan, HMO, PPO, etc.).
E. Website address –brochure: If available, the URL link to the specific product brochure from the issuer.
F. Website address –Formulary: If available, a URL link to a list of prescription drugs, both generic and brand name that are available through the health product.
G. System for Electronic and Rate Form Filing (SERFF) number – At the request of states, the SERFF number by which many states accept applications for product level form filings will be added to product records for update starting in September 2010. This unique identifier will be extremely helpful for tracking and matching product level data to plan information and administrative records.

Provider network information

Insurance products are generally characterized by three different types of health care provider arrangements: exclusive providers, any providers, and mixed where particular incentives are offered for using certain providers. These mixed and exclusive arrangements are generally identified as "provider networks." In pertinent cases, we require that a link to that information on the web be provided. This is a necessary

requirement to inform consumers as to the ability of a product to pay within their existing health care relationships, and is essential information on how to obtain an appropriate physician once a plan has been chosen.

A. Website address –Provider Network: If available, a URL link to a listing of exclusive or preferred care providers.