

Appendix E - Benefits and Pricing

September 3 Data Requirement: Benefits and Pricing

As Section 1103(b)(2) makes clear, the ability of consumers to decide on affordable health care options requires additional information on benefits and cost sharing associated with a product. Specifically, the Secretary requires information on the “percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act), eligibility, availability, premium rates, and cost sharing with respect to such coverage options.”

To ensure accurate information, consistent presentation, and to minimize the burden on issuers, collection of this data will be delayed until after the May 21 collection. As of September 3, 2010, however, issuers will be required to provide information as specified below.

Medical Benefits Information

- A. **Deductible:** The specified dollar amount for which consumers are responsible for health care costs before the health insurance plan begins to pay for health care services. If a deductible applies to the plan we will require that this information be provided.
- B. **Coinsurance:** We will require a brief description of when co-insurance is applied, and what percentage is covered.
- C. **Out of Pocket Limit:** This is defined as an annual cap on the amount of money individuals are required to pay out-of-pocket for health care costs, excluding the premium cost.
- D. **Primary Care Physician Required:** This factor has significant effects on the relationship between a patient and their doctor, and as such is of importance to consumers, thus the Secretary will require it be reported.
- E. **Specialist Referrals Required:** issuers will need to indicate to consumers whether a referral from their primary care physician is needed before seeing a specialist.
- F. **HSA Eligibility:** Health Savings Accounts HSAs are one avenue used by many consumers to manage overall health care expenses. We will ask whether HSAs are supported under the plan.
- G. **Office Visits:** The specified dollar amount, co-pay or coinsurance percentage associated with specific types of office visits. Types of visits will include: primary care physician office visit, specialist visits, periodic health exams, OB-GYN exam visits, and well baby care. Additional types of visits such as chiropractic and mental health will also be requested based on their importance to particular consumer segments.
- H. **Prescription drug benefits:** Insurance plans can treat prescription drug coverage differently, greatly affecting the costs for particular consumers. We will require issuers to provide the main dimensions of their drug coverage to ascertain co-pays, co-insurance and deductible for formulary drugs, brand name drugs, and generic drugs obtained from pharmacies or through mail order.
- I. **Additional Coverage:** Other factors which are critical for individuals choosing insurance will be covered with specific questions regarding Lab/X-Ray work, Emergency Room visits, Outpatient Surgery, Hospitalization, Pre & Postnatal office visits, and Labor & Delivery Hospital Stays. We will require brief descriptions of the coverage of these items.
- J. **Dental Benefits:** A description of dental benefits will be required, including whether there is a separate plan into which one is automatically enrolled, annual deductibles and maximums,

coverage of general preventative procedures as well as more expensive options such as dental surgery and orthodontics.

- K. Out-of-Network Coverage: A yes or no field regarding whether out of network care is covered combined with brief descriptions of the plan on this aspect will be required (including deductible, coinsurance, out-of-pocket-limit, referral and pre-authorization requirements)
- L. Out-of-Country Coverage: A yes/no or short description of whether care obtained outside the country is covered under the plan. This information may be of critical importance to consumers who travel internationally.

Eligibility and Rating Information

Various factors go in to the calculation of an individual consumer's out-of-pocket expenses for an insurance package. Currently, many states allow for medical underwriting which can affect a person's actual premiums through such issues as life-style choices and pre-existing medical conditions. To accurately reflect these issues, it will be imperative to gather information about how the issuer determines insurance rates.

The secretary will explore the best way to reflect these myriad differences in pricing schemes to provide the best estimate of costs possible. This may result in minor changes to the exact request, but the data requirement will cover:

- A. US citizenship. Is US citizenship required for plan membership.
- B. Domestic Partnerships: Can domestic partners be covered under this plan
- C. State citizenship: Under some plans, an applicant must have resided within the state for a certain period of time before coverage will be extended. We will require those limits be identified.
- D. Other eligibility requirements: In cases where other non-health related questions are used to determine eligibility, the secretary will require that these be specified.
- E. Age limits: Some plans have a maximum or minimum age for either primary applicants or for dependents. In cases where this is true, we will those limits will be noted.
- F. Family Calculations: Some plans have separate family deductibles, out of pocket expenses, and/or maximums for coverage. The Secretary will ascertain whether these conditions exist and how they relate to the quoted personal amounts.
- G. Effective Dates: Given enrollment periods may sometimes differ, as can the time period during which rates are in effect. issuers will be required to identify the appropriate dates.
- H. How often do rate updates typically occur?
- I. Other categories: issuers in different states may apply a variety of specific non-medical conditions for membership or for the application of different pricing schemes. Plans may be limited to non-smokers, available only to particular occupations, or be subject to any number of limits. Where such categorical determinations exist, the issuers will be required to identify them.
- J. Administrative Fees: If monthly fees are required by the plan, we will require that they be specified for the consumer.
- K. Issuer fee Conditions: If issuer fees are applied, issuers will be required to identify the conditions for their application and calculation.
- L. Rate calculation: Individual rates may be calculated on a number of different dimensions even before medical underwriting or even if medical underwriting doesn't apply. Issuers will be required to provide information on how their rates are calculated. It is anticipated that most issuers will be able to provide this by use of a "rate table" providing a breakdown by variables such as gender, age, and a few additional variables. In cases where such tables do not adequately describe rating by the issuer, the issuer will provide a programmatic description of their rating formula in a step by step formula. Where issuers maintain a verification source which allows for third party comparisons, this information will be provided to allow the Government to review results from whatever calculations are required on our part.

