

HEALTH CARE REFORM INSURANCE WEB PORTAL REQUIREMENTS
Summary of Interim Final Rule with Comment Period
May 5, 2010

On April 30, 2010, the Office of the Secretary of the Department of Health and Human Services (HHS) released for display at the *Federal Register* an interim final rule with comment period (IFR) for implementing an insurance web portal required under section 1103(a) of the Patient Protection and Affordable Care Act (PPACA) (P.L. 110-148) as amended by section 10102(b) of the same act. The rule was published in the *Federal Register* on May 5th. With this IFR, 45 CFR Subtitle A, Subchapter B, is amended by adding a new part 159 entitled **Part 159 – HEALTH CARE REFORM INSURANCE WEB PORTAL.**

PPACA requires the web portal to be operational by July 1, 2010. To meet this deadline, HHS has determined the need to waive the notice and comment process and proceed directly to an interim final rule. The rule is effective as of May 10, 2010. Although the web portal will become available by July 1st, an expanded version, including insurance premium information, will become operational on October 1, 2010. **Comments are due to HHS on the IFR no later than 5 p.m. on June 4, 2010.**

I. BACKGROUND

PPACA directs the Secretary of HHS (“Secretary”) to immediately establish a mechanism, including an internet website, through which a resident of, or small business in, any state may identify affordable health insurance coverage options in that state. The major goal is to create a website (web portal) that will “empower consumers by increasing informed choice and promoting market competition.” Information will be made available to consumers in a “clear, salient, and easily navigated manner.” To do this, HHS plans to “minimize the use of technical language, jargon, or excessive complexity in order to promote the ability of consumers to understand the information and act in accordance with what they have learned.” Consumer testing will be used to identify the “best methods to achieve these goals.”

HHS notes that in obtaining information to populate the web portal from health insurance issuers, the department anticipates adopting electronic submission capabilities. In addition, HHS is “seeking to balance the need to obtain information that will promote informed choice with the principles of the Paperwork Reduction Act and Executive Order 12866, which call for minimizing burdens and maximizing net benefits. ***To that end, HHS is “seeking comments on how best to achieve that balance, and in particular how to reduce unnecessary burdens on the private sector.”***

A. Statutory Basis

PPACA requires that the web portal, to the extent practicable, provide, at a minimum, information on the following coverage options:

- Health insurance coverage offered by health insurance issuers;
- Medicaid;
- CHIP;
- State health benefits risk pool coverage;

- Coverage under the high risk pool created by section 1101 of PPACA (the temporary risk pool program); and
- Coverage within the small group market for small businesses and their employees.

This information is required to be presented in a standardized format. Specific types of information must be presented including the percentage of premium revenue expended on nonclinical costs (i.e., Medical Loss Ratio (MLR)), eligibility, availability, premium rates, and cost sharing. The format must be consistent with the standards that are adopted for the uniform explanation of coverage under section 2715 of the Public Health Service Act (PHSA) which is newly added by PPACA. (Because these standards are not due until March 23, 2011, they will not be in place for the July 1, 2010 release of the portal but they will be the basis for changes once they become available.) This IFR defines what HHS will publish as the minimum content of the web portal.

B. General Overview

As noted, HHS intends to make the web portal available for public use by July 1, 2010, the statutory deadline. The future development and updating of the web portal will be “an evolutionary process that involves all stakeholders, and we anticipate future updates, including annual and periodic revisions, to be released as the result of a continued refinement of the web portal content.”

For July 1st, the content will include summary information about health insurance products that are available to the individual and small business markets including:

- Issuers of the products,
- Types of products,
- Location,
- Summaries of services offered,
- Links to provider networks, and
- Contact information (including website links and customer service telephone contact) to enable interaction with specific issuers.

In addition, the web portal will provide information on eligibility, coverage limitations and premium information for existing high risk pools operating in the states. The portal will also provide introductory information on eligibility and services for Medicaid and CHIP. It will include contact information and website links for the Medicaid and CHIP programs for individuals who believe that they or family members may meet eligibility criteria; in addition, information will be provided on coverage options for small businesses, including reinsurance for early retirees under section 1102 of PPACA and the small business tax credits available under section 45R of the Internal Revenue Code, as added by section 1421 of PPACA. Website links to these programs will also be included so that small businesses can obtain further information.

HHS intends to enhance the portal’s content over time to include more information than required by the statutory minimum, including any information that it has that would be “useful to consumers,” such as medical loss ratios, quality and performance information, links to appropriate websites and more state specific information on Medicaid and CHIP eligibility and service coverage. “However, because of the complexity of pricing information and the need to incorporate pricing engines into the website, detailed pricing

and benefit information will be provided in the second release of the web portal on October 1, 2010.”

II. PROVISIONS OF THE INTERIM FINAL RULE

A. Definitions

In addition to the definitions used in title I of PPACA for terms such as “health insurance coverage,” “health insurance issuer,” and so on, HHS defines three additional terms for purposes of the web portal:

“Health insurance product” is used as a short-hand reference to the information that HHS will publish in the first release of the web portal. This term is needed in order to differentiate the information that will be collected for the July 1, 2010 release and the post-July 1, 2010 releases. It means a package of benefits that an issuer offers that is reported to state regulators in an insurance filing.

“Portal plan” describes certain data that HHS will collect and disseminate in post-July 1, 2010 releases of the web portal. Because each package of benefits may be paired with a multitude of cost sharing options, “portal plan” refers to the discrete pairing of a package of benefits with a particular cost-sharing option (not including premium rates or premium rate quotes). HHS will collect portal plan information for publication in post-July 1, 2010 releases of the web portal.

B. Individual and Small Group Market Data Collection and Dissemination

To facilitate the development of a web portal with comprehensive pricing and benefit information on individual and small group coverage, HHS plans to contract with a vendor that has a health insurance pricing engine and a related website with portal plan identification and comparison functionality through full and open competition. However, the work on the contract will not be completed in time for the July 1, 2010 release of the web portal. Accordingly, HHS will collect an initial set of data (health insurance product information) from issuers in order to present basic information on all issuers and health insurance products in the July 1, 2010 release. HHS will provide a second release on October 1, 2010 with comprehensive pricing and benefit information for individual and small group coverage.

1. DATA SUBMISSION

HHS states that it will communicate to consumers through the web portal and other public communication processes, such as presentations and reports to stakeholders, the names of those issuers who fail to timely meet the reporting requirements or who provide incomplete or inaccurate information.

a. July 1, 2010. To meet this deadline, HHS will require issuers to provide data that it will use to develop introductory information for consumers on the universe of issuers and health insurance products in their geographic area. By May 21, 2010, issuers must submit:

- corporate and contact information;
- administrative information, such as enrollment codes;
- enrollment data by product;

- product names and types, such as Preferred Provider Organization (PPO) or Health Maintenance Organization (HMO);
- whether enrollment is currently open for each product;
- geographic availability information, such as product availability by zip code or county;
- customer service phone numbers;
- website links to the issuer website;
- brochure documents such as benefit summaries and provider networks; and
- financial ratings, such as those offered by financial rating firms including AM Best, Standards and Poor, and Moody's, if available.

HHS seeks comment on whether enrollment information is considered by issuers to be confidential business information.

Because some insurers vary on whether they obtain financial ratings and other performance measures, HHS is requiring each issuer to submit information on whether they obtain a financial rating, from which firm, and what the rating is. This information will be used by HHS to help analyze whether such ratings are or could be useful in conveying meaningful differences to consumers. Moreover, HHS will allow, but not require issuers to report other types of ratings they have received, such as ratings from the National Committee for Quality Assurance (NCQA) Accreditation.

b. October 1, 2010. On this date, HHS will release a more comprehensive version of the web portal. Data submissions for this release are due by September 3, 2010. This more comprehensive portal will include benefit and pricing information. Benefit and pricing information includes data such as premiums, cost-sharing options, types of services covered, coverage limitations, and exclusions. For states in which premiums are not community rated, the premium data that will be collected include manual rates that represent only standard risks. HHS explains that there is no feasible method for collecting or displaying information on the rate that an individual who is underwritten might actually be charged.

HHS further states that while the initial release of the portal will list all issuers and all health insurance products, users may be confused if the department were to display portal plans that are not open for enrollment. Also, it would be inappropriate to impose a pricing and benefits information reporting burden on issuers for products and portal plans that are not open for enrollment. Therefore, HHS will exempt issuers of products and portal plans that are not open to new enrollments from additional pricing and benefits reporting requirements. However, such issuers will be required to provide the data defined under the May 21 collection to assure that HHS has the universe of issuers and their health insurance products. If the insurer then introduces new products or plans, it will be required to submit pricing and benefits information within 30 days of offering new, or newly reopened, to enrollment, products or portal plans.

To provide for a meaningful presentation of available options, HHS has decided to include on the portal all plans that have a non-de minimus portion of the issuer's enrollment in an area and allowing for additional plans to be submitted based on the issuers' perception of need. Therefore, for each zip code, issuers will be required to submit information on at least all portal plans that are open for enrollment and that represent 1 percent or more of the issuer's total enrollment for the respective individual

or small group market within that zip code. **HHS invites comments on what information should be required from issuers to ensure consumer access to meaningful information about coverage options is included in the web portal, and on the ways that information should be presented. Comments are requested from consumers on ways to make certain that the web portal meets the needs of those individuals who will use it as part of their health coverage decision making.**

c. Future updates. After the initial data collection efforts described above, HHS will require issuers to perform an annual verification and update of the data they submitted. Issuers will have to submit updated data whenever they change premiums, cost-sharing, types of services covered, coverage limitations, or exclusions for one or more of their individual or small group portal plans. Also, issuers that develop new health insurance products between annual verifications will have to submit pricing and benefit information for the new product within 30 days of opening enrollment.

In addition, HHS will collect from issuers and report on the web portal in 2011 the following performance ratings:

- Percent of individual market and small group market policies that are rescinded;
- The percent of individual market policies sold at the manual rate;
- The percent of claims that are denied under individual market and small group market policies; and
- The number and disposition of appeals on denials to insure, pay claims and provide required pre-authorizations.

Updated data, including the required data updates previously discussed and annual verifications, must be submitted by issuers in accordance with instructions issued by the Secretary in a future Paperwork Reduction Act Package.

d. Data Validation. All data collected for the July 1, 2010, October 1, 2010, and future releases of the web portal will be validated by the issuers to assure the information they provided is correct. The issuer's chief executive officer (CEO) or chief financial officer (CFO) will be required to electronically certify to the completeness and accuracy of the initial data collection for the October 1, 2010 release of the web portal and for any future updates to these requirements. Following the data submission, HHS will provide issuers with access to preview the data that it will publish on the web portal and access to edit their data submissions to update or correct information.

2. VOLUNTARY DATA SUBMISSION BY STATES

HHS is requesting that states submit data on issuer corporate and contact information for licensed issuers; underwriting status, such as whether or not premium rates in the individual market are determined based on medical underwriting or community rating; and information on any public websites administered by the state that provide consumer guidance on individual and small group health insurance coverage in their state.

Gathering these data from both states and issuers will help HHS in determining the universe of plan options and ensure that HHS is not inadvertently excluding an issuer or product as a result of incomplete data collection. The underwriting information and website links will be included on the web portal in an effort to develop consumer education content and incorporate (by way of linking) any state-developed information

on insurance coverage options in a given state. HHS anticipates that states will be responsive to this request because the information requested will enhance the ability of the citizens of each state to identify affordable options for insurance.

3. DATA DISSEMINATION

a. July 1, 2010. On July 1, 2010, the portal will include information on the data collected as a result of the May 21, 2010 data submission mandate, including information for consumers on the issuers that sell individual and small group products in their area and links to benefit information for those products. Also, HHS will provide some consumer education information on the individual market, including describing how it operates and why its offerings might be appropriate for a consumer, as well as information that will facilitate health insurance coverage decision-making and increased understanding of how the web portal operates. In addition, it will include information for small businesses on the small group market, including information on the PPACA reinsurance and tax credit programs.

b. October 1, 2010. On this date, the web portal will include expanded content that will incorporate the data collected as a result of the September 3, 2010 data submission mandate described above with the data collected for the May 21, 2010 mandate. The display of portal plans will be driven by interactive functionality that accounts for geographic and personal demographic information such as state and zip code of residence, sex, family composition, smoking status and other health indicators. HHS intends for the order and layering of search results to be based on consumer choice parameters such as range of premium, high and low deductibles, ranges of out-of-pocket maximums, provider network, and indicators of market interest in the product including enrollment. It intends that consumers will also have the ability to select on all available issuers and portal plans and view them alphabetically. ***HHS invites comments on the sort and selection functionality of the web portal, and on the order and layering of portal plans that HHS will display.***

HHS also will retain and enhance the consumer education content established for the July 1, 2010 web portal release.

c. Future Updates. HHS will update the portal plan pricing and benefit information as frequently as monthly to reflect updates that issuers submit as a result of changes to their portal plans. Consumer education content will be updated periodically in the event that new and pertinent information about either of the individual or small group markets becomes available that would be beneficial for a consumer to know.

PPACA requires HHS to provide information on the percentage of total premium revenue expended on nonclinical costs, as reported under section 2718(a) of the PHSA. HHS will report MLRs to meet this requirement, which will provide more than the minimally required information and is believed to be more useful to the public. Section 2718 of the PHSA requires issuers to report this information to HHS beginning with plan years starting on or after September 23, 2010, and the Secretary is promulgating rules on these reporting requirements. After the regulations for this provision are implemented, HHS anticipates including MLR information on the web portal.

HHS expects to include portal plan performance rating information, such as:

- Percent of individual market and small group market policies that are rescinded,

- The percent of individual market policies sold at the manual rate,
- The percent of claims that are denied under individual market and small group market policies, and
- The number and disposition of appeals, on the web portal in the future.

Also, HHS expects to include information derived from standards and reporting obligations that will apply to insurance sold under the exchange (e.g., information on issuers' financial stability). PPACA requires the Secretary to develop quality measures and standards to inform the public about quality of care and to drive improvements in the service delivery system. When these measures/standards are available, they will be incorporated into the web portal. ***HHS invites comments on the content of future updates to the web portal, including the frequency of updates, the inclusion of performance rating information, and the incorporation of quality measures and standards.***

C. Information to be Collected and Disseminated on High Risk Pool Coverage

To meet PPACA requirements, HHS must establish a mechanism for collecting and preparing information on state high risk pools for public dissemination in a clear and concise fashion.

1. DATA SUBMISSION REQUEST

a. July 1, 2010. HHS will ask the National Association of State Comprehensive Health Insurance Plans (NASCHIP) for information about state health benefit high risk pools, including administrative and contact information; pool eligibility information; pool coverage limitations; and pool premium information. Since this information is already collected by NASCHIP, HHS will ask the association to provide the data by May 21, 2010.

b. Future Updates. Because state health benefits high risk pools are updated on an annual calendar-year basis, HHS is asking NASCHIP to provide annual updates of the information for the May 21, 2010 data collection. If NASCHIP is unable to provide these data, HHS will ask state health benefits high risk pools to provide them.

HHS requests that any State health benefits high risk pool that is established after May 21, 2010, including any high risk pool established pursuant to section 1101 of PPACA, report the requested information within 30 days of when the pool begins accepting enrollment, and then annually thereafter.

2. DATA DISSEMINATION

a. July 1, 2010. This release of the portal will include eligibility, coverage limitations and premium information as collected under the request as described above, as well as consumer education content that would aid consumer understanding about high risk pools generally, and whether such pools might offer a potential source of coverage for them.

b. Future Updates. These will include updates to the eligibility, coverage, and premium information. These updates may include data for new high risk pools that are established subsequent to the July 1, 2010 release of the web portal, including those established

pursuant to section 1101 of PPACA. (NASCHIP intends to build a website to contain detailed information that today is only available in NASCHIP's hard copy annual report. HHS will, therefore, also provide a link to the NASCHIP website in a future release.)

D. Information to be Disseminated on Medicaid and CHIP

PPACA simplifies Medicaid and CHIP income eligibility rules for most populations beginning January 2014. HHS says that in the meantime, individuals will need to directly contact their state programs for definitive determinations of their eligibility or for their family members. The web portal is intended as a resource for consumers to educate them about their eligibility for Medicaid and CHIP and provide information about how they can contact their state programs to determine eligibility and services available to them.

HHS will provide information guiding consumers on general eligibility criteria for the individual state programs. The web portal will also be designed to offer links to the various state Medicaid and CHIP agencies in order to facilitate consumers' submission of program applications. For each eligibility category, the web portal will present information regarding the mandatory and optional services (and waiver programs) that are available to eligible applicants. General cost sharing requirements will also be presented, to the extent that they are permitted for the eligibility category in these programs. The portal will include data elements for mandatory services for each mandatory and optional categorical group defined in each Medicaid State plan. If states include optional services in their Medicaid State plan, the portal will include data elements to reflect the availability of optional services. Additional program specific service information will be provided with regard to section 1115 Demonstration programs designed by states as well as services provided through CHIP.

In addition, the web portal will provide information to consumers on the Home and Community-Based Waiver program, including a broad range of state defined services that enable independence in a consumer's own home.

All of the above data will be derived from sources internal to CMS and include Medicaid State Plan Amendments, CHIP State Plans, CHIP annual reports, home and community based waivers applications and renewals, 1115 Demonstration documents, and the contacts database used for www.cms.gov which includes consumer contacts to state Medicaid and CHIP program offices. Information will come from data that CMS already collects for program management and administration purposes.

HHS observes that certain state-based variations in Medicaid and CHIP programs, such as specific income and resource disregards, and variations in services, such as limits on the number of visits, cannot be presented with a high degree of detail in early releases of the web portal. HHS expects to list the services and note that there are limitations, giving consumers enough information to ask questions of the state program if they pursue an application to enroll. HHS also cautions that some of the information will be presented on the portal in an aggregated format to enhance public understanding. For example, eligibility categories may be collapsed together for purposes of maximizing public understanding.

III. WAIVER OF PROPOSED RULEMAKING AND THE 30-DAY DELAY IN THE EFFECTIVE DATE

HHS justifies moving directly to an interim final rule because it finds good cause to waive the notice-and-comment procedure. HHS explains that the notice and comment procedure would be impracticable given the PPACA requirement that it establish the web portal by a July 1, 2010. In order to meet this mandate, it has to collect and prepare for dissemination a broad array of data on issuers, health insurance products, and plans. And it cannot do this without making issuers aware of the data submission requirements in “short order” and states, associations and high risk pools “are made aware of opportunities to aide in this information dissemination effort within the established narrow timeframes.” HHS needs the data that are to be included on the web portal in the July 1, 2010 release no later than May 21, 2010. HHS further explains that it is providing a 30-day period for public comment. The schedule will allow for a 10-day comment period prior to the initial reporting requirement under these regulations. HHS elaborates on the time required to complete the various tasks required to get the portal up and operational by July 1, 2010 and the process by which it developed the interim final rule.

IV. COLLECTION OF INFORMATION REQUIREMENTS

Under the Paperwork Reduction Act of 1995, HHS is required to provide 60-day notice in the *Federal Register* and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that HHS solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of the estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

HHS is soliciting public comment on each of these issues as they are treated in this section of the IFR.

As described above, health insurance issuers are required to submit via a specified template furnished by the Secretary, corporate and contact information; administrative information; enrollment data and other specified data on or before May 21, 2010, and annually thereafter. In this section of the rule, HHS elaborates on its estimate of administrative burden (time and costs) for issuers. The summary table is included below.

Table 1. Recordkeeping and Reporting Burden

Regulation Section(s)	OMB Control No.	Respondents	Responses	Burden per	Total Annual	Hourly Labor	Total Labor	Total Capital/Maintenance	Total Cost (\$)
				Response (hours)	Burden (hours)	Cost of Reporting (\$)	Cost of Reporting (\$)	Costs (\$)	
§159.120(a)	0938-1086	650	650	30	19,500	100	1,950,000	0	1,950,000
		650	650	.317	206	65	13,390	0	13,390
§159.120(b)	0938-1086	650	650	4	52,000	65	3,380,000		3,380,000
§159.120(c) and (d)	0938-1086	650	13,000	1	13,000	65	845,000	0	845,000
Total		650	14,950		84,706				6,188,390

V. RESPONSE TO COMMENTS

HHS will consider all comments submitted by the deadline and will respond to them in the preamble to a subsequent document.

VI. REGULATORY IMPACT STATEMENT

HHS has concluded that this rule does not have economic impacts of \$100 million or more or otherwise meets the definition of a “significant rule.” It, therefore, has not included a regulatory impact estimate. The rationale for this decision is presented.

HHS observes that for planning, oversight, preparation and maintenance of the portal web site, the federal government will incur an estimated \$11 million in one-time costs in 2010 and \$12 million to oversee and operate in 2011 annually thereafter. In total, it estimates costs for the federal government, state governments and the private sector in calendar 2010 to be about \$17 million and annually thereafter to be about \$15 million.

HHS clarifies that nothing in this interim final rule prevents other parties from aggregating and presenting information similar to what will be presented on the web portal and gives the Massachusetts Connector website as an example. HHS also notes that several online companies aggregate and present information for some of the policies sold in all or most states and brokers and agents, as well as some consumer organizations, present information on subsets of plans to their client target groups in their geographic areas. HHS observes that its web portal “may facilitate such efforts and improve the scope and accuracy of information provided by alternative sources.” In this light, HHS observes that “[to] the best of our knowledge no web sites include such a broad range of health care coverage and specific plan information on a national scale, with the intent of serving such a broad range of consumers needing health insurance coverage. (There are, however, similarly broad portals for some specific population groups, such as Medicare beneficiaries and Federal employees).”

HHS requests comments on the following:

- Whether it should limit the number of plan variations on which it presents information for an issuer in a particular area to those that represent at least 1 percent of their total enrollment in that area (i.e., never more than 100 variations and usually far fewer).

- The likely costs and benefits of this rule as presented, on alternatives that would improve the consumer and small business purchaser information to be provided, and on the quantitative estimates of burden.
- Comments are welcome to address both regulatory changes and changes that might be made through administrative decisions in planning and implementing the web portal.
- Comments on ways to design the web portal to best meet consumer information needs.