DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 159

Health Care Reform Insurance Web Portal Requirements

RIN 0991-AB63

AGENCY: Office of the Secretary, HHS.

ACTION: Interim final rule with comment period.

SUMMARY: The Patient Protection and Affordable Care Act (the Affordable Care Act) was enacted on March 23, 2010. Section 1103(a), as amended by section 10102(b) of the same act, requires the establishment of an internet website (hereinafter referred to as a web portal) through which individuals and small businesses can obtain information about the insurance coverage options that may be available to them in their State. The Department of Health and Human Services (HHS) is issuing this interim final rule in order to implement this mandate. This interim final rule adopts the categories of information that will be collected and displayed as web portal content, and the data we will require from issuers and request from States, associations, and high risk pools in order to create this content.

DATES: Effective date*:* These regulations are effective on May 10, 2010.

Comment date*:* To be assured consideration, comments must be received at the address provided below, no later than 5 p.m. on

[OFR--insert date 30 days after date of publication in the **Federal Register]**.

ADDRESSES: In commenting, please refer to file code DHHS-9997-IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed)

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions on the home page.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: DHHS-9997-IFC,

P.O. Box 8014,

Baltimore, MD 21244-8014.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: DHHS-9997-IFC,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance

to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Danielle Harris, (410)786-1819.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services,

7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

The Patient Protection and Affordable Care Act (Pub. L. 111-148), hereinafter referred to as the Affordable Care Act, was enacted on March 23, 2010. Section 1103(a), as amended by section 10102(b) of the same act, directs the 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.

In implementing these requirements, we seek to develop a website (hereinafter called the web portal) that would empower consumers by increasing informed choice and promoting market competition. To achieve these ends, we intend to provide a web portal that provides information to consumers in a clear, salient, and easily navigated manner. We plan 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. We will engage in careful consumer testing to identify the best methods to achieve these goals.

In obtaining information to populate the web portal, we will be seeking all the statutorily required information from issuers,

and we anticipate adopting electronic submission capabilities. As we develop the web portal, and engage with consumers, this information will be used to create an effective consumer-friendly presentation of affordable health coverage option plans. In addition, we plan to provide information, consistent with applicable laws, in a format that is accessible for use by members of the public, allowing them to download and repackage the information, promoting innovation and the goal of consumer choice.

As we develop the web portal, we are also 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, we are seeking comments on how best to achieve that balance, and in particular how to reduce unnecessary burdens on the private sector.

This is an interim final rule that becomes effective May 10, 2010. We invite public comments on all relevant issues to make improvements.

A. Statutory Basis

As discussed above, Section 1103(a)of the Affordable Care Act, as amended by section 10102(b) of the same act, directs the 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. To the extent practicable, the website (hereinafter called the web portal) is to provide, at minimum, information on the following coverage options:

1. Health insurance coverage offered by health insurance issuers,
2. Medicaid coverage,
3. Children's Health Insurance Program (CHIP) coverage,
4. State health benefits high risk pool coverage,
5. Coverage under the high risk pool created by section 1101 of the Affordable Care Act, and
6. Coverage within the small group market for small businesses and their employees.

In order to provide this information in a standardized format, section 1103(b) requires the Secretary to develop a standardized format to present the coverage information described above. This format is to provide for, at a minimum, the inclusion of 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. 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. This format is defined in the Paperwork Reduction Act (PRA) package published at [**PRA package citation**]. Defining the

minimum content of the format required under section 1103(b) in effect defines what we will publish as the minimum content of the web portal. This regulation, therefore, specifies the data that will be collected and disseminated through the web portal in accordance with 1103(a) as amended by section 10102(b).

B. General Overview

Section 1103(a) of the Affordable Care Act, as amended by section 10102(b) of the same act, requires the establishment of a web portal through which individuals can obtain information about the health insurance options that may be available to them in their "State." Section 1304(d) of the Affordable Care Act defines "State" to include the fifty states and the District of Columbia. The territories are not included in this definition. We therefore will interpret "State" in the web portal context to mean the 50 States and the District of Columbia.

By statute, the web portal must be available for public use no later than July 1, 2010. We will use the data collections and processes described in this rule to make the initial release of the web portal available to the public on July 1, 2010, through a government sponsored website. We intend for the future development and updating of the web portal to 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.

In the July 1, 2010 release we will provide summary information about health insurance products that are available in 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, to the extent that it is provided to us by the responding parties. It will also provide introductory information on eligibility and services for Medicaid and CHIP. We 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, we will provide information on coverage options for small businesses, including reinsurance for early retirees under section 1102 of the Affordable Care Act (which is being administered by HHS), and tax credits available under section 45R of the Internal Revenue Code, as added by section 1421 of the Affordable Care Act. We also will include website links to these programs so that small businesses can obtain further information.

We note that Section 1103(b)(1) requires the Secretary to present the web portal information in a format that is consistent with the standards that are adopted for the uniform explanation

of coverage under section 2715 of the Public Health Service Act (PHSA) as added by section 1001(a) of the Affordable Care Act. Section 2715 of the PHSA provides for the establishment of these standards within 12 months of the Affordable Care Act's enactment date. As a result, these standards will not be in place for the July 1, 2010 release of the web portal. We will modify the format used to present the initial release of the web portal to ensure web portal consistency with these standards in accordance with the implementation schedule that is established for these standards.

In an effort to make the web portal as comprehensive as possible, we will enhance the content over time to include more than the statutory minimum requirements that are discussed above. We will include any information that we have that we believe would be useful to consumers, such as medical loss ratios, quality and performance information, links to appropriate websites such as the website of the association that represents existing State health benefits high risk pools, and more State-specific information on Medicaid and CHIP eligibility and service coverage. 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.

As we discuss in more detail in section III "Waiver of Proposed Rulemaking and the 30-Day Delay in the Effective Date,"

the statutory requirement for a July 1, 2010 web portal release does not allow time for full notice and comment rulemaking. While this timeframe necessitates going directly to final, in order to maximize public input we are using an interim final rule with comment to establish the categories of information that we will collect for inclusion in the web portal, including the data production requirements that we impose on health insurance issuers, and the data collection requests for States, associations, and high risk pools.

II. Provisions of the Interim Final Rule

A. Definitions

For any terms defined by the Affordable Care Act, including the definitions in section 1304, as well as any definitions in the Public Health Service Act that are incorporated by reference under sections 1301(b) or 1551 of the Affordable Care Act, we adopt those definitions. We discuss these definitions below. The regulatory text provides cross references to these provisions. We also explain here how we are defining the terms that are not defined in the Affordable Care Act or the PHSA. These terms are "State health benefits high risk pool," "section 1101 high risk pool," "health insurance product" and "portal plan."

Section 2791(b)(1) of the PHSA, as incorporated by reference into the Affordable Care Act, defines "health insurance coverage" as "benefits consisting of medical care (provided

directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer." Section 2791(b)(2) in turn defines an insurance issuer (also referred to here as an "issuer") to be an entity "licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance" and specifies that it does not include a group health plan.

For purposes of the Affordable Care Act and the PHSA, a distinction is made between health insurance coverage sold to group health plans, and other health insurance coverage. The term "group health plan," as defined in section 2791(a)(1) of the PHSA, exclusively refers to health coverage sold to group health plans. Section 1304(a)(2) of the Affordable Care Act, which adopts the identical definition as section 2791(e)(1)(A) of the PHSA, defines "individual market" as the "market for health insurance coverage offered to individuals other than in connection with a group health plan."

Section 2791(b)(5) of the PHSA in turn defines "individual health insurance coverage" as health insurance coverage "offered to individuals in the individual market, but does not include short-term limited duration insurance."

The Affordable Care Act and the PHSA further divide the group health insurance market into coverage sold to large employers (the "large group market," and coverage sold to small employers (the "small group market"). See section 1304(a)(3) of Affordable Care Act. Section 1304(b)(2) of the Affordable Care Act defines a "small employer" as, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average at least 1, but not more than 100 employees on business days during the preceding calendar year, and who employs at least 1 employee on the first day of the plan year. Section 1304(b)(3) of the Affordable Care Act allows for a State to elect the option to define "small employer" as an employer who employed on average at least 1, but not more than 50 employees on business days during the preceding calendar year in the case of plan years beginning before January 1, 2016. As such, for any State that elects this option, we would apply this alternate definition of "small employer" for their State for plan years beginning before January 1, 2016.

For purposes of this regulation, we will refer to health insurance coverage offered to employees of small employers in the small group market as "small group coverage."

Sections 1103(a)(2)(D) of the Affordable Care Act provides for web portal reporting of "State health benefits high risk pools." For the purpose of this rule, we define "State health benefits high risk pools" as nonprofit organizations created by

State law to offer comprehensive health coverage to individuals who otherwise would be unable to secure such coverage because of their health status. This language was adopted, with modification, from the National Association of Comprehensive Health Insurance Plans (NASCHIP) annual report. Our understanding is that this definition is generally understood to identify existing high risk pools.

Section 1103(a)(2)(E) provides for web portal reporting of pools established pursuant to section 1101 of the Affordable Care Act. For purposes of this regulation, we define "section 1101 high risk pools" as any entity described in regulations implementing section 1101 of the Affordable Care Act.

The Affordable Care Act and the PHSA do not include the term "health insurance product." We are creating this term as a short hand reference to the information that we 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. We define "health insurance product" ("product") as a package of benefits that an issuer offers that is reported to State regulators in an insurance filing.

The Affordable Care Act and the PHSA also do not define the term "portal plan." We are creating this term to describe certain data that we will collect and disseminate in post-July 1, 2010 releases of the web portal. We understand that consumers

apply for coverage under individual health insurance products that issuers develop and market to offer a package of benefits. In applying for a package of benefits, we further understand that consumers are offered a range of cost-sharing arrangements, including deductibles and copayments but not including premium rates or premium rate quotes. As a result, each package of benefits can be paired with a multitude of cost sharing options. We will use the word "portal plan" to refer to the discrete pairing of a package of benefits with a particular cost-sharing option (not including premium rates or premium rate quotes). We will collect portal plan information for publication in post-July 1, 2010 releases of the web portal. We believe that portal plan information is precise enough to provide a potential consumer with enough information to discern the relative costs and benefits of selecting a particular coverage option.

We welcome comments on the adequacy of these definitions, and, if applicable, suggestions to improve them.

B. Individual and Small Group Market Data Collection and Dissemination

In order to meet the mandate, we must collect information on individual and small group coverage from health insurance issuers and prepare the information to be presented publicly in a clear and concise fashion. We will have a two part rollout of the web portal for 2010, and then annual and periodic updates to allow

for the inclusion of updated data as well as consumer education content.

1. Data Submission Mandate

The Secretary currently regulates health insurance industry practices for private insurance plans offered through public programs such as Medicare, Medicaid, and CHIP. While she either has or has access to data on Federal government sponsored plans, we must issue regulations to mandate the production of the necessary information from issuers in order to fulfill the statutory mandate as it applies to private plans not offered through Federal government programs. To facilitate the development of a robust web portal with comprehensive pricing and benefit information on individual and small group coverage, our current plan is to contract with a vendor that has a health insurance pricing engine and a related website with portal plan identification and comparison functionality through a full and open competition. The work on this contract will not be completed in time for the July 1, 2010 release of the web portal. Accordingly, we 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 of the web portal. This release of the web portal will only contain the basic information on issuers and their products in the individual and small group markets that was practicable to obtain in the constrained timeframe for meeting

the statutory requirement that the web portal be available for public use by July 1, 2010. We will provide a second release of the web portal on October 1, 2010 with comprehensive pricing and benefit information for individual and small group coverage.

We 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 the July 1, 2010 deadline, we will require issuers to provide data that we 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 we will require issuers to submit corporate and contact information, such as corporate addresses and websites; 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.

We invite comment on whether enrollment information is considered by issuers to be confidential business information.

We are aware that some issuers are rated on their financial status and other performance measures. We considered excluding issuers with no or low financial ratings from firms such as AM Best, Standard and Poor, and Moody. However, it is our understanding that not all issuers seek financial ratings, and that the private firms that conduct them do not use standardized approaches. Therefore, we will instead require each issuer to submit information on whether they obtained a financial rating, from which firm, and what the rating is. We will use this information to help analyze whether such ratings are or could be useful in conveying meaningful differences to consumers. For the same purpose we 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.

Certain administrative information that we are collecting, such as an issuer's technical contact information (that is, the person who will work directly with us and our contractors to submit and validate data), tax identification number, and enrollment count in an issuer's products, will be used to support the structure of the database in which this information will be

warehoused so that the data can be easily retrieved to support uploading information to the web portal test site, and so that issuers and their portal plans can be reliably recognized by HHS and issuers and counted to support analyses for improving the web portal. This information will also be used to support analysis necessary to improve the meaningfulness and usefulness of the web portal in future releases. In addition, certain contact information will allow the Federal government and its contractors to provide useful updates and reminders to issuers and to provide technical support.

Data submitted under the requirements contained in this regulation must be submitted by issuers in accordance with instructions issued by the Secretary in [**PRA package citation**].

b. October 1, 2010

We will release a more comprehensive version of the web portal on October 1, 2010. This version 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.

We note that for States in which premiums are not community rated, the premium data that we intend to collect will include manual rates that represent only standard risks. As a result of medical underwriting, issuers may charge individuals rates that are above the manual rate based on the applicant's health status. We recognize that there is not a feasible method for collecting

or displaying information on the rate that an individual who is underwritten might actually be charged, and in the absence of that are proposing to provide information on the manual rates with the understanding that they do not represent actual premium rates that an individual may be charged.

While the initial release of the web portal will list all issuers and all health insurance products, we believe that it would confuse users if we were to display portal plans that are not open for enrollment. Furthermore, we believe that it is inappropriate to impose a pricing and benefits information reporting burden on issuers for products and portal plans that are not open for enrollment. Therefore, we will exempt issuers of products and portal plans that are not open to new enrollments from additional pricing and benefits reporting requirements. Such issuers will be required to provide the data defined under the May 21 collection to assure we have the universe of issuers and their health insurance products.

In the event that an issuer establishes new products or new portal plans under a product, or opens enrollment in products or portal plans under a product that was previously closed to enrollment, we will require the submission of the pricing and benefits information within 30 days of offering new, or newly re-opened to enrollment, products or portal plans.

We considered excluding issuers with minimal market share from the benefits and cost sharing data collection. However, we

believe that some of the portal plans offered by these issuers serve niche markets that would be particularly appealing to some consumers. At this time, we will include portal plans with minimal market share, but we will collect enrollment data for use in analyzing the effect, if any, of market share and our ability to meet consumer needs.

The intent of the web portal is to present consumers with the full range of meaningful insurance options available to them. We believe this will be best accomplished through providing 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. Our initial overview of the market indicates that most areas have coverage which is concentrated in a limited number of portal plans. One percent of an issuers' enrollment in the service area was seen as a reasonable cut off balancing the consumer's right to know with the burden imposed on issuers. 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.

We invite comments from the public 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

to allow for sorting and comparing portal plans. We are particularly interested in comments from consumers, 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.

The data submissions for the October 1, 2010 web portal release will be due by September 3, 2010. Data must be submitted by issuers in accordance with instructions issued by the Secretary in [**PRA package citation**].

c. Future Updates

After the initial data collection efforts described in the prior two subsections, we will require issuers to perform an annual verification and update of the data they submitted. In addition, we recognize that many issuers update pricing and benefit information for their portal plans more frequently than annually, and we therefore will require issuers 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. Furthermore, we will require issuers that develop new health insurance products between annual verifications to submit pricing and benefit information for the new product within 30 days of opening enrollment.

Finally, while not included in the statutory list of minimum requirements for the web portal, we 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 preauthorizations.

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 that is 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. We will require the issuer's CEO or CFO 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 submission of the data, we will provide issuers with access to preview the data that we will publish on the web portal. They will also be provided with access to edit their data submissions to update or correct information.

2. Voluntary Data Submission by States

We are requesting that States submit data on issuer corporate and contact information for licensed issuers in their

State, such as corporate addresses and websites; 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.

It is our understanding that States possess the issuer corporate and contact information we are requesting them to submit as a result of their filing requirements for regulated issuers. We are requesting that States voluntarily submit issuer corporate and contact information because we believe that it is incumbent upon us to ensure that we provide information on the entire universe of issuers and health insurance products. Gathering these data from both States and issuers will help us in determining the universe and ensure that we are not inadvertently excluding an issuer or product as a result of incomplete data collection.

The underwriting information and website links we are requesting from States 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. We recognize that some States may have already developed web portals that provide comprehensive information about health insurance coverage in their State, and we will link to that information if it is available.

In asking States to provide the data identified above, we note that the information would improve the accuracy and scope of the information we can provide to consumers in each of the States. We expect that States will want to ensure full access to information about issuers, health insurance products and portal plans to their residents. We believe that doing so would support consumer choice and a more robust marketplace for insurance. We therefore anticipate 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

We will disseminate the information collected as a result of our data submission mandates as described above, as well as other information about health insurance coverage in the individual and small group market that may be useful to the public.

a. July 1, 2010

On July 1, 2010 the web portal will include information on the data collected as a result of the May 21, 2010 data submission mandate outlined above, 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. In addition, we 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 the context of the Affordable Care Act. We also will include information for small businesses on the small group market, including information on the reinsurance and tax credit programs discussed previously.

b. October 1, 2010

On October 1, 2010 the web portal will include expanded content that will incorporate the data collected as a result of the September 3, 2010 data submission mandate outlined above with the data collected for the May 21, 2010 mandate previously discussed. Using the pricing and benefit information gathered as a result of the September 3rd collection, we will display portal plans as packages of benefits and cost sharing, with associated premiums, based on geographic availability.

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. We intend 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. We intend that consumers will

also have the ability to select on all available issuers and portal plans and view them alphabetically.

We invite comments on the sort and selection functionality of the web portal, and on the order and layering of portal plans that we will display.

Certain administrative data collected for the October 1 web portal release will not be displayed directly on the web portal but these data are important to the functionality of a pricing engine, such as input data that defines the geographic and demographic variables that affect premium price and cost sharing that will be displayed on the web portal.

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

c. Future Updates

We 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. As discussed previously, because issuers may update pricing and benefit information more frequently than annually, we are requiring updated data submissions whenever an issuer changes the premiums, cost-sharing, types of services covered, coverage limitations, or exclusions for one or more of their individual or small group portal plans. Our monthly updates will also reflect these updates. Consumer education content will be updated periodically in the event that new and pertinent information

about either of these markets becomes available that would be beneficial for a consumer to know.

In addition, we are required by section 1103(b)(1) to provide information on the percentage of total premium revenue expended on nonclinical costs, as reported under section 2718(a) of the Public Health Service Act (PHSA). We will report medical loss ratios 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 we anticipate including medical loss ratio information on the web portal.

As discussed previously, we anticipate including 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.

We also anticipate posting information derived from standards and reporting obligations that will apply to insurance sold under the exchanges. For example, we might post information on issuers' financial stability, trends in enrollment and

disenrollment, appeals and grievances, and other indicators of fiscal viability, customer service and policy-holder satisfaction.

The Affordable Care Act directs 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 such measures and standards become available they will be incorporated into the web portal.

We invite comments on the content of futures 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

Sections 1103(a)(2)(D) and (E) of the Affordable Care Act requires HHS to include information about State health benefits high risk pools and high risk pools established under section 1101 of the Affordable Care Act. In order to fulfill this mandate, HHS must establish a mechanism for collecting and preparing this information for public dissemination in a clear and concise fashion.

1. Data Submission Request

Pursuant to the requirement that the web portal include information on coverage through these high risk pools, this rule requests that certain information on State health benefits high

risk pools and high risk pools that will operate under authority established in section 1101 of the Affordable Care Act be reported.

a. July 1, 2010

We will ask the National Association of State Comprehensive Health Insurance Plans (NASCHIP) for information about State health benefit high risk pools. This information will include administrative and contact information, such as a customer service phone number and a website for pool information; pool eligibility information, such as state residency and health condition requirements; pool coverage limitations, such as restrictive riders; and pool premium information, such as rules and restrictions for premium subsidy programs. We understand that this information is currently collected and maintained by NASCHIP, and that all of the existing State health benefits high risk pools are members of NASCHIP. As such, we believe that NASCHIP is strategically equipped to work with the State health benefits high risk pools to gather and transmit data to HHS on behalf of State health benefits high risk pools. Therefore, we will ask NASCHIP to provide the data as discussed above by May 21, 2010.

b. Future Updates

We understand that coverage that is offered by State health benefits high risk pools is updated on an annual calendar-year basis. We will therefore ask NASCHIP to provide annual updates

of the information that we will request for the May 21, 2010 data collection. If NASCHIP is unable to provide this information in the future, we will ask State health benefits high risk pools to provide this information.

Because the initial release of the web portal is July 1, 2010, which is in the middle of a calendar-year, we will initiate the annual update data submission requests in the fall of 2010.

In addition, we request 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 the Affordable Care Act, 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

The July 1, 2010 release of the web 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

Future updates to the high risk pool content of the web portal will include updates to the eligibility, coverage, and premium information requested above. 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 the Affordable Care Act. We understand NASCHIP intends to build a website to contain detailed information that today is only available in NASCHIP's hard copy annual report. We will therefore also provide a link to a NASCHIP website in a future release in order to provide even more comprehensive information on those State health benefits high risk pools that are represented by NASCHIP.

D. Information to be Disseminated on Medicaid and CHIP

Sections 1103(a)(2)(B) and (C) of the Affordable Care Act require that Medicaid and CHIP information be included on the web portal. Title XIX of the Social Security Act, the law governing the Medicaid program, has allowed States broad discretion over Medicaid eligibility policy and therefore, Medicaid eligibility varies widely across States. In general, Medicaid eligibility is dependent on categorical and income requirements. Title XXI of the Social Security Act outlines the eligibility rules in CHIP and such eligibility requirements are generally based on certain income requirements for children under age 19. There are instances where pregnant women and parents can be eligible for CHIP. The Affordable Care Act simplifies Medicaid and CHIP income eligibility rules for most populations beginning January 2014. In the meantime, individuals will need to directly contact their State programs for definitive determinations of their eligibility

or for their family members. However, the web portal can serve as a resource to educate potential beneficiaries that they or their family members may be eligible for Medicaid and CHIP and provide information about how they can contact their State programs to determine eligibility and services available to them. The portal will serve as a resource for understanding what their State Medicaid and CHIP programs generally cover and how to apply for benefits.

To implement sections 1103(a)(2)(B) and (C) we will provide information guiding consumers on general eligibility criteria for the individual State programs in an effort to assist them in assessing the need to pursue the application processes for these programs. There are no new reporting requirements to support implementation of this section. The data will come from existing Federal sources. 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 services that are available to eligible applicants. General cost sharing requirements will also be presented on the web portal, to the extent that they are permitted for the eligibility category in these programs.

In order to provide this information, data are being compiled within CMS across all Medicaid and CHIP eligibility categories regarding the services available under each program.

This includes both mandatory and optional Medicaid services for which States receive Federal funding as defined in each State Medicaid plan and any waiver of such plan, as well as the services available under each State's CHIP plan and any waiver of such plan. Mandatory services are specific services States are required to cover for certain groups of Medicaid beneficiaries, both adults and children under the age of 21. Each required service is defined in Federal regulations 42 C.F.R. Part 440. Optional Medicaid services are defined as those services not required by Federal law that States may elect to provide Medicaid beneficiaries. Optional services are also defined in Federal regulation at 42 C.F.R. Part 440. CHIP regulations define mandatory and optional services at 42 C.F.R Part 457.

The portal will include data elements for mandatory services for each mandatory and optional categorical group defined in each Medicaid State plan, such as: inpatient hospital care (excluding inpatient services in institutions for mental disease for working age adults); outpatient hospital care; physician's services; nurse midwife services; pediatric and family nurse practitioner services; laboratories and x-ray services; rural health clinic services including Federally qualified health centers ("FQHC") and if permitted by State law, rural health clinic and other ambulatory services provided by a rural health clinic which are otherwise included under a State Medicaid plan; prenatal care and family planning services, skilled nursing facility services for

persons over age 21, home health care services for persons over 21 who are eligible for skilled nursing services (includes medical supplies and equipment), early and periodic screening, diagnosis, and treatment for persons under age 21 ("EPSDT"), necessary transportation services, and vaccines for children.

If States include optional services in their Medicaid State plan, they must be provided in a manner that is consistent with all Federal requirements. The web portal will include data elements to reflect the availability of optional services such as home health therapy services, rehabilitative services, case management services, medical or remedial care services or other licensed practitioners (chiropractors, podiatrists, optometrist, psychologists and nurse anesthetists), smoking cessation services and palliative care for children in each State Medicaid plan. Additional program specific service information will be provided with regard to Demonstration programs designed by States under the authority of section 1115 of the Social Security Act as well as services provided through the Children's Health Insurance Program.

Appropriate information on a specific State's Demonstration programs, including variations in eligibility, coverage and service delivery systems used under the Demonstrations, will also be provided on the portal. Demonstrations that are Statewide or high impact, meaning that they have a significant penetration in the market and serve more than a narrow coverage group, will also

be included in the initial release of the web portal. Other Demonstration programs in Medicaid and CHIP will be added in future releases.

Additionally, the web portal will provide information to consumers on the Home and Community-Based Waiver program (Section 1915(c) of the Act), 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. We are not collecting any new data elements for the Medicaid and CHIP portions of the web portal under the authorities that were granted to us under section 1103 of the Affordable Care Act. All information will come from data that CMS already collects for program management and administration purposes.

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. We expect 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.

Finally, while a significant amount of data is being compiled to populate the web portal, some of the data for the Medicaid and CHIP portion will be presented in an aggregated format to enhance public understanding. For example, eligibility categories may be collapsed together for purposes of maximizing public understanding. By way of example, there are several working disabled eligibility categories in Medicaid that inter-relate. We would expect, given the complexity of these definitions, that consumers may have difficulty fully understanding these categories. Therefore, we are presenting the public with summary-level information, such as collapsing information about the working disabled into one category.

III. Waiver of Proposed Rulemaking and the 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with 5 U.S.C. section 553(b) of the Administrative Procedure Act (APA). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause for concluding that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates

a statement of the finding and its reasons in the rule issued.

Section 1103(a), as amended by section 10102(b), and section 1103(b) of the Affordable Care Act provide for the establishment by July 1, 2010 of a web portal through which a resident or small business of any State may identify affordable health insurance coverage options in that State. In order to meet this mandate, we have to collect and prepare for dissemination a broad array of data on issuers, health insurance products, and plans, including administrative and product information for the individual and small group markets; information on eligibility and coverage limits for high risk pools; and information on eligibility and services for Medicaid and CHIP. This cannot be accomplished unless issuers are made 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. In order to allow sufficient time for data submission and validation prior to public presentation, we must be in possession of the data that is to be included on the web portal in the July 1, 2010 release no later than May 21, 2010.

As a result of this data collection timeline, it is impracticable to issue a notice of proposed rulemaking prior to publishing a final rule that would implement these data production requirements. Therefore, we find good cause to waive notice and comment rulemaking, and we are proceeding with issuing

this final rule on an interim basis. We are providing a 30-day public comment period.

In addition, we ordinarily provide a 30-day delay in the effective date of the provisions of an interim final rule. While the Administrative Procedures Act (5 U.S.C. §§ 551 et seq.) generally requires the publication of a substantive rule not less than thirty days prior to its effective date, agencies may establish a shorter time frame based on good cause. 5 U.S.C. § 553(d)(3). In accordance with the good cause basis explained below, these regulations are effective on May 10, 2010.

Section 1103(a) of the Affordable Care Act requires the public release of the web portal on July 1, 2010. As shown below, a sequenced order of activities must be completed in order to meet this statutory deadline.

Data will be uploaded into the database supporting the web portal to populate the web portal test site, and based on observations adjustments to the actual website may be made. Any problems with the actual data would be adjusted as well. This is a four week iterative process that continues until the test site is functioning and presenting data output as expected, which begins with the first data upload on June 3 and ends with the release of the web portal on July 1.

Prior to this, the data that is submitted must be formatted in preparation for upload to the database that supports the web portal test site. First upload to the test site takes

approximately two days, from June 1 to June 3. There can be subsequent uploads through June 14, as noted below.

Prior to this, beginning May 21, we must have time to view the submitted data to assure it is complete and clean. At this same time we believe that the regulated parties should be offered an opportunity to validate the data they submit and resubmit any erroneous data. We believe that the minimum time required to accomplish such work is three weeks, which brings us to June 14, 2010. There is a 10 day overlap between this process and the two processes described above.

Prior to this, we must afford those submitting the data with adequate time to gather and submit the data. We believe that the minimum time that should be provided for this work is 7 business days from May 12 through to May 21, 2010.

In order to submit that data, these parties will need to establish accounts that will allow secure data entry into the data collection tool. This will entail approximately 3 business days from May 10 to May 12.

Furthermore, we anticipate that these parties will need training and guidance on gathering data, obtaining an account and entering data. This will include a webinar on or about May 7 and other technical support through a help desk. This collection of activities would take at least 4 business days which brings us to May 12, 2010.

Thus, in order to meet the statutory deadline of July 1, 2010, the processes described above must commence no later than May 10, 2010.

Furthermore, certain activities had to occur within the agency prior to our being able to publish a rule to implement the web portal requirements, or enter the contracts necessary to support work under this rule. The Affordable Care Act was enacted on March 23, 2010. We immediately established a workgroup to analyze policy options and the contractual and regulatory needs of the web portal program. This work was completed on April 22. We then commenced task-specific workgroups to draft the necessary documents, including this regulation, and to procure the initial contractors. While these activities would usually take at least 6 months we have accomplished them in just under six weeks. It was impossible to have accomplished this work any faster, and the brief timeframe between the publication of this document and the effective date of its provisions could not have been avoided through more diligent use of time by the individuals working to implement this mandate.

To afford a full thirty days between publication and the effective date we would be have to hold the parties submitting the data and ourselves to inadequate timeframes in which to accomplish the necessary tasks. The timeframes and dates

described above therefore establish good cause for an effective date that is fewer than thirty days after publication.

We will accept comments on the content of this regulation until **[OFR enter date 30 days from publication of reg].** This schedule will allow for a ten day comment period prior to the initial reporting requirement under these regulations.

IV. Collection of Information Requirements

In accordance with section 3507(j) of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 et seq.), the information collection included in this interim rule have been submitted for emergency approval to the Office of Management and Budget (OMB). OMB has assigned control number XXXX-XXXX to the information collection requirements.

Under the Paperwork Reduction Act of 1995, we are 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 we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our 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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

ICRs Regarding Data Submission for the Individual and Small Group Markets (§159.120)

Section 159.120(a)requires health insurance issuers (issuers), in accordance with guidance issued by the Secretary, to submit corporate and contact information; administrative information; enrollment data by health insurance product; health insurance product name and type; whether enrollment is currently open for each health insurance product; geographic availability information; customer service phone numbers; and website links to the issuer website, brochure documents, and provider networks; and financial ratings on or before May 21, 2010, and annually thereafter. The information must be submitted via a template furnished by the Secretary. The burden associated with these reporting requirements is both the time and effort necessary to review the regulations, analyze data, and train issuer staff and the time and effort necessary for an issuer to compile the

necessary information, to download and complete the template, and to submit the required information. We estimate that this requirement affects 650 issuers. We believe it will take each issuer 30 hours to review the regulations, analyze data, and train its staff on how to comply with the requirements. The total one-time burden associated with this requirement is 19,500 hours. The estimated cost associated with complying with this part of the requirement is $1,950,000.

Based on our experience with Medicare Part C, we also estimate that each issuer will submit information on 9 of its portal plans and that it will take each issuer a total of 19 minutes to download the information submission template, complete the template, and submit the template. The estimated annual burden associated with the requirements in §159.120 is 206 hours. The estimate cost associated with complying with these requirements is $13,390.

Section 159.120(b) requires issuers, in accordance with the guidance issued by the Secretary, to submit pricing and benefit data for their portal plans on or before September 3, 2010, and annually thereafter. The information must be submitted via a template furnished by the Secretary. The burden associated with this requirement is the time and effort necessary for issuers to compile and submit pricing and benefit information. We estimate that it will take each of the 650 issuers 533 minutes to comply with these requirements. The total annual burden associated with

these requirements is 51,968 hours. The estimated cost associated with complying with these requirements is $3,377,920.

Section 159.120(c) requires issuers to submit updated pricing and benefit data for their portal plans 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. Section 159.120(d) requires issuers to submit pricing and benefit data for portal plans associated with products that are newly open or reopened for enrollment within 30 days of opening for enrollment. Each submission would include a certification on the completeness and accuracy of the submission. The burden associated with these requirements is the time and effort necessary for an issuer to submit the aforementioned data. While these requirements are subject to the PRA, we do not have sufficient data to estimate the associated burden. We do not know the frequency with which issuers will make the aforementioned updates. For that reason, we are estimating a total burden of 1 hour for these requirements. The estimate of one hour acknowledges that there is a burden associated with this requirement. The total estimated annual burden to industry associated with these updates is 13,000 hours, or 20 hours per issuer. This estimate is based on a three times a year, 19 minute per batch response update. The total cost associated with this requirement is $845,000.

Section 159.120(e) requires issuers to annually verify the

data submitted under §159.120(a) through (d). Section 159.120(f) requires issuers to submit administrative data on product and performance rating information for future releases of the web portal in accordance with guidance issued by the Secretary. While these requirements are subject to the PRA, we will seek OMB approval at a later date under notice and comment periods separate from this interim final rule with comment.

Table 1: Recordkeeping and Reporting Burden

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

This interim final rule imposes information collection requirements as outlined in the regulation text and specified above. However, this interim final rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections.

State Data Submissions

As previously stated in Section II.B.2 of the preamble of this interim final rule, we are requesting that States, in accordance with guidance issued by the Secretary, submit issuer corporate

and contact information, underwriting status, and information on any State-administered websites that provide consumer information on health insurance coverage in their State by May 21, 2010. The information must be submitted via a template furnished by the Secretary.

The burden associated with these voluntary reporting requests is both the time and effort necessary to review the regulations, analyze data, and train issuer staff and the time and effort necessary for an issuer to compile the necessary information, to download and complete the template, and to submit the required information. We estimate that this request affects all 50 States and the District of Columbia. We believe it will take each State 10 hours to review the preamble discussion, analyze data, and train its staff on how to comply with the request. The total one-time burden associate with this request is 500 hours. The total estimated cost associated with complying with this part of the requirement is $50,000.

We further estimate that it will take each State a total of 10 minutes to download the information submission template, complete the template, and submit the template. The estimated annual burden associated with this request is 8 hours. The estimated cost associated with complying with this request is $520.

Data Submissions for High Risk Pools

As discussed in section II.C.1 of the preamble of this

interim final rule, we are asking the National Association of State Comprehensive Health Insurance Plans (NASCHIP) to provide data pertaining to the information listed in section II.C.1., in accordance with guidance issued by the Secretary, no later than May 21, 2010. In the event that NSACHIP is unable to provide this information, State health benefits high risk pools have been asked to submit it to HHS. While this request is subject to the PRA, we anticipate that this information will be collected from NASCHIP. Therefore, we are not assigning any burden to these entities within the first year of this collection.

In section II.C.1, we also request that NASCHIP or State health benefits high risk pools submit annual updates on the aforementioned information. While these requests are subject to the PRA, we will seek OMB approval at a later date under notice and comment periods separate from this interim final rule with comment.

Similarly, in the case of a high risk pool established under section 1101 of the Affordable Care Act, we are requesting that the pool submit to HHS the aforementioned information within thirty days of accepting enrollment and then annually thereafter. While these requests are subject to the PRA, we will seek OMB approval at a later date under notice and comment periods separate from this interim final rule with comment.

All of the information collection requirements contained in this interim final rule were submitted to the Office of

Management and Budget (OMB) for emergency review and approval as part of a single information collection request (ICR). As part of the emergency review and approval process, OMB waived the notification requirements. The ICR was approved under OMB control number 0938-XXXX with an expiration date of [Month Day, Year]. However, we are still seeking public comments on the information collection requirements discussed in this interim final rule with comment. All comments will be considered as we continue to develop the ICR as we must resubmit the ICR to obtain a standard 3-year approval.

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, DHHS-9997-IFC

Fax: (202) 395-6974; or

Email: OIRA submission@omb.eop.gov

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this preamble, and, when we proceed with a

subsequent document, we will respond to the comments in the preamble to that document.

VI. Regulatory Impact Statement

We have examined the impacts of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104-4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2).

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). As discussed below, we have concluded that this rule does not have economic impacts of $100 million or more or otherwise meet the definitions of "significant rule" under EO 12866.

Based primarily on data that we have obtained from the National Association of Insurance Commissioners (NAIC), we believe that there are about 650 insurance firms that sell insurance in the individual and small group markets and are hence

subject to this interim final rule. This estimate is consistent with other data on the size of the health insurance industry estimated by HHS in previous rulemakings. In addition, about 50 States and other governmental entities will be encouraged to provide voluntarily administrative data on Medicaid and CHIP and (as applicable) data on high risk pool programs. We estimate that on average these approximately 700 respondents will spend 40 hours of time reading this rule, determining what information sources will be used to respond, determining how to provide that information in the newly required formats, and completing a certification on the completeness and accuracy of the information. Assuming that high level staff (for example, managers, attorneys, actuaries, and senior IT professionals) are involved in these efforts, at an average compensation cost of $100 an hour, total one-time costs will be approximately $3 million dollars. Actual provision of data we estimate to cost approximately $3 million a year both in the first year and annually thereafter. Federal government planning, oversight, preparation, and maintenance of the portal web site we estimate to cost $11 million in one-time costs in 2010, and $12 million to oversee and operate in 2011 and annually thereafter. In total, we estimate costs in calendar 2010 to be approximately $17 million, and annual costs thereafter to be approximately $15 million. Additional detail on these estimates can be found in the Paperwork Reduction Act section of this preamble and we welcome

comment on them.

All or virtually all of the information needed for the web portal is standard information that is already made available to individuals, insurance agents, or existing IT contractors with pricing engines and other entities that sell or otherwise provide health insurance to individuals and small groups. For example, information on deductibles, coverage, cost-sharing, and catastrophic protection limits is routinely available on all or virtually all insurance available to individuals or small groups. Nothing in this rule requires preparation of entirely new information. In essence, we simply require that relatively comprehensive information be provided in standardized formats so that plan comparisons can be automated in ways that present comparable information in comparable levels of detail to facilitate consumer understanding of available choices. We believe that carriers that offer large numbers of plans will find that once they have determined how best to provide the data for a few of those plans, adding additional plans will involve very little if any additional cost. We have also limited the number of plans on which carriers will be required to provide data. Because we appreciate that the time schedule provided in the statute is extremely short, and because the Federal government itself needs time to prepare and populate its web portal, we have provided for two data submissions in 2010, the first in May and a second more detailed collection in September. This will provide the Federal

government with the time needed to competitively bid for a contractor that has a sophisticated pricing engine, as well as for issuers and States time to plan for and compile some of the more detailed information that we are deferring until later in the year.

Nothing in this interim final rule prevents other parties from aggregating and presenting similar information. For example, the State of Massachusetts already presents essentially the entire set of information we will obtain, and more, on its Connector web site. Several online firms aggregate and present information for some of the policies sold in all or most States. Many insurance brokers and agents, and some consumer organizations, present information on subsets of plans available to their client target groups in their geographic areas. In fact, the web portal we will provide may facilitate such efforts and improve the scope and accuracy of information provided by alternative sources.

As specified in the statute, our web portal will include the range of insurance coverage options available to individuals or small businesses, including both public (for example, Medicaid, CHIP, and high risk pool) and private plans, and all types of plans including health maintenance organization, preferred provider organization and indemnity plans. 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).

It is difficult if not impossible to quantify the benefits of such a broad expansion of consumer information. Moreover, the benefits of this information will change over time, most importantly as State-specific insurance exchanges expand their presence. We do believe, however, that the benefits of improved information will facilitate informed consumer choices as well as benefit the insurance market more broadly. We expect that our web portal will inform State decisions on the design of exchanges both by positive example and, doubtless, through ideas on ways to improve on the information and formats and tools we provide. Among the likely effects of this effort will be increased use of State high risk insurance pools, increased sale of private policies to uninsured individuals, increased enrollment in Medicaid and CHIP, and commensurate reductions in spending on care for the uninsured. We believe, however, that the most important effect of the web portal will be to improve health insurance coverage choices. For example, private plans that offer better benefit packages at lower premium costs are likely to benefit from improved consumer information.

We have considered a range of alternatives to the web portal approach we describe in this final rule with comment, including

both more and less ambitious efforts. For example, we could provide less complete information on health insurance coverage choices, and rely on States and private efforts to provide more complete comparisons. In our view, however, costs would not be significantly less were we to require less plan-specific information. Moreover, the full range of information we specify is likely to facilitate other efforts. For example, we do not believe that any other service has been able to assemble in one source information on all insurance issuers and programs serving the individual and small group markets across a broad range of States. One specific alternative on which we request comment is on our proposal to limit the number of plan variations on which we present information for an issuer in a particular area to those that represent at least one percent of their total enrollment in that area (that is, never more than 100 variations, and usually far fewer). Without such a limitation, if a particular issuer offers twenty or more possible products and twenty alternative cost sharing arrangements applied to the products in a particular geographic area, the combinations and permutations of offerings would be 400 for this one issuer alone. Our use of zip codes for plan service areas is an essential simplifying approach to reducing the number of alternative plans presented, by eliminating irrelevant plans, but does not solve this problem.

We welcome comments on 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 our 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 our Internet portal to best meet consumer information needs are especially welcome.

The RFA requires agencies to analyze options for regulatory relief of small businesses, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small government jurisdictions. Small businesses are those with sizes below thresholds established by the Small Business Administration (SBA). We examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis we determined that there were few if any insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the SBA. In fact, then and even more so now, the market for health insurance is dominated by a relative handful of firms with substantial market shares. For example, nationally the approximately 40 Blue Cross and Blue Shield

companies account for approximately half of all private insurance sold in the United States. A recent GAO study focused on the small business market and found that the five largest issuers in the small group market, when combined, represented three-quarters or more of the market in 34 of 39 States for which this information was available (GAO, February 27, 2009, Private Health Insurance: 2008 Survey Results on Number and Market Share of Issuers in the Small Group Health Insurance Market). These firms included Blue Cross companies, and also other major insurers such as United HealthCare, Aetna, and Kaiser. Small government jurisdictions do not sell insurance in the individual or small business markets. There are, however, a number of health maintenance organizations (HMOs) that are small entities by virtue of their non-profit status, including Kaiser, even though few if any of them are small by SBA size standards. There are approximately one hundred such HMOs. These HMOs and those Blue Cross and Blue Shield plans that are non-profit organizations, like the other firms affected by this interim final rule, will be required to provide information on their insurance policies to the Department. Accordingly, this interim final rule will affect a "substantial number" of small entities.

We estimate, however, that the one-time costs of this interim final rule are approximately $5 thousand per covered entity (regardless of size or non-profit status) and about $5 thousand annually both in the first year and thereafter. Numbers

of this magnitude do not remotely approach the amounts necessary to be a "significant economic impact" on firms with revenues of tens of millions of dollars (usually hundreds of millions or billions of dollars annually). Moreover, the Regulatory Flexibility Act only requires an analysis for those final rules for which a Notice of Proposed Rule Making was required. Accordingly, we have determined, and certify, that this rule will not have a significant economic impact on a substantial number of small entities and that a regulatory flexibility analysis is not required.

In addition, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. This interim final rule would not affect small rural hospitals. Therefore, the Secretary has determined that this rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1195 requires that agencies assess anticipated costs and benefits before issuing any rule that includes a Federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation.

That threshold level is currently about $135 million. This interim final rule contains reporting mandates for private sector firms, but these will not cost more than the approximately $6 million that we have estimated. It includes no mandates on State, local, or tribal governments.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule and subsequent final rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications. This interim final rule does not impose substantial direct requirement costs on State and local governments, preempt State law, or otherwise have Federalism implications.

In accordance with the provisions of Executive Order 12866, this interim final rule was reviewed by the Office of Management and Budget.

List of Subjects in 45 CFR Part 159

Administrative practice and procedure, Computer technology, Health care, Health facilities, Health insurance, Health records, Hospitals, Medicaid, Medicare, Penalties, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Subtitle A, Subchapter B, by adding a new part 159 to read as follows:

Part 159 – HEALTH CARE REFORM INSURANCE WEB PORTAL

Sec.

Authority: Section 1103 of the Patient Protection and Affordable Care Act (Pub.L. 111-148).

§159.100 Basis and scope.

This part establishes provisions governing a web portal that will provide information on health insurance coverage options in each of the 50 States and the District of Columbia. It sets forth data submission requirements for health insurance issuers. It covers the individual market and the small group market.

§159.110 Definitions.

For purposes of part 159, the following definitions apply unless otherwise provided:

Health Insurance Coverage: We adopt the Public Health Service Act (PHSA) definition of "health insurance coverage" found at section 2791(b)(1) of the Public Health Service Act (PHSA).

Health Insurance Issuer: We adopt the PHSA definition of "health insurance issuer" found at section 2791(b)(2) of the PHSA.

Individual Health Insurance Coverage: We adopt the PHSA definition of "individual health insurance coverage" found at section 2791(b)(5) of the PHSA.

Individual Market: We adopt the Affordable Care Act definition of "individual market" found at section 1304(a)(2) of the Affordable Care Act and 2791(e)(1)(A) of the PHSA.

Small Employer: We adopt the Affordable Care Act definition of "small employer" found at section 1304(b)(2) and (3).

Small Group Coverage: means health insurance coverage offered to employees of small employers in the small group market.

Small Group Market: We adopt the Affordable Care Act definition of "small group market" found at section 1304(a)(3).

State Health Benefits High Risk Pools: means nonprofit organizations created by State law to offer comprehensive health insurance to individuals who otherwise would be unable to secure such coverage because of their health status.

Section 1101 High Risk Pools: We define section 1101 high risk pools as any entity described in regulations implementing section 1101 of the Affordable Care Act.

Health Insurance Product: means a package of benefits that an issuer offers that is reported to State regulators in an insurance filing.

Portal Plan: means the discrete pairing of a package of benefits and a particular cost sharing option (not including premium rates or premium quotes).

§159.120 Data submission for the individual and small group markets.

(a) Health insurance issuers (hereinafter referred to as issuers) must, in accordance with guidance issued by the Secretary, submit corporate and contact information; administrative information; enrollment data by health insurance product; product names and types; whether enrollment is currently open for each health insurance product; geographic availably information; customer service phone numbers; and website links to the issuer website, brochure documents, and provider networks; and financial ratings on or before May 21, 2010, and annually thereafter.

(b) Issuers must, as determined by the Secretary, submit pricing and benefit information for their portal plans on or before September 3, 2010, and annually thereafter.

(c) Issuers must submit updated pricing and benefit data for their portal plans 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.

(d) Issuers must submit pricing and benefit data for portal plans associated with products that are newly open or newly reopened for enrollment within 30 days of opening for enrollment.

(e) Issuers must annually verify the data submitted under paragraphs (a) through (d), and make corrections to any errors that are found.

(f) Issuers must submit administrative data on products and portal plans, and these 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 preauthorizations, for future releases of the web portal in accordance with guidance issued by the Secretary.

(g) The issuer’s CEO or CFO must electronically certify to the completeness and accuracy of all data submitted for the October 1, 2010 release of the web portal and for any future updates to these requirements.

RIN 0991-AB63

Dated: _____

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Jay Angoff,

Director,

Office of Consumer Information and

Insurance Oversight.

Dated: _____

_____

Kathleen Sebelius,

Secretary.

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