DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: October 29, 2015

Subject: CMS Final Bulletin on Out-Of-Pocket (OOP) Cost Comparison Tool for the Federally-facilitated Marketplaces (FFMs)

I.   Purpose

The Centers for Medicare & Medicaid Services (CMS) has developed an Out-of-Pocket (OOP) Cost Comparison Tool to help consumers make more informed choices about their health insurance coverage and to help them pick a plan that will best meet their needs. The OOP Cost Comparison Tool allows shoppers in the Federally-facilitated Marketplaces (FFMs) to see estimates of total spending (to include premiums and cost-sharing) across various health insurance plans.   The purpose of this bulletin is to provide information on the OOP Cost Comparison Tool, how the tool computes OOP Cost, and how it is incorporated into the FFMs' web sites. This comparison tool will be available to consumers on October 25, 2015 for the 2016 annual open enrollment period beginning November 1, 2015 (for coverage effective starting as soon as January 1, 2016).

II.   Comments

This document is revised from the Proposed Bulletin on the OOP Cost Comparison Tool for the FFMs that was released on May 29, 2015, where we welcomed public input on the three key areas of the OOP Cost Comparison Tool methodology including: (1) the utilization and cost data; (2) use of health plans' cost sharing data; and (3) user input regarding consumer demographics, such as the number of family members, age, gender, and expected healthcare utilization. We also sought comments regarding whether it would be helpful to make the source code of an OOP Cost Comparison Tool available for use by State-based Marketplaces (SBMs) including the timing and preferred format for providing this information.

We appreciate the commenters' feedback, and as stated in the Bulletin, the OOP Cost Comparison Tool will be available to consumers shopping for all medical plans in the individual Federally-facilitated Marketplaces as well as individual medical plans in the SBMs whose states utilize the federal platform. In response to comments associated with the areas requested, we

have made revisions to the methodology to provide additional clarification and function of the OOP Cost Comparison Tool.

Some of those revisions to the methodology are as follows:

- CMS will map Rehabilitation Services to a specific Plans and Benefit Template category (Rehabilitation Services)
- CMS has trended the MarketScan Commercial Claims and Encounters Database to reflect projected calendar year 2016 data
- CMS has revised the Cost Sharing Variants (CSVs) for the Indian population
- For the medium or average utilization level, CMS has set the decile to 5.5, the average of the fifth and sixth decile, to reflect the median level
- CMS has updated cost sharing data for the Ambulance Trips benefit category

Please note that we received additional comments that were not related to our specific proposals for the Out-of-Pocket (OOP) Cost Comparison Tool for the Federally-facilitated Marketplaces. We appreciate the commenters' feedback and will take these comments into consideration when developing program requirements for future years for the OOP Cost Comparison Tool. Although not technically feasible for the 2016 open enrollment period, CMS will be considering releasing the code to SBMs for implementation in future years, beginning with 2017 open enrollment, if technically feasible.

III.   Introduction

One feature of a health plan finder web site that consumers and other stakeholders suggest would be helpful is a comparison tool that allows potential enrollees to see, for their particular situation, an estimate of total spending for all health plans meeting certain user-specified requirements. Those estimates provide a more complete picture when they include both monthly premiums and an indication of out-of-pocket (OOP) cost, which, for this purpose, includes copayments, coinsurance, deductibles, and uncovered expenses.

One difficulty with providing an exact OOP cost valuation for any given consumer is that OOP costs depend on the quantity of healthcare services used by the consumer during the relevant year. In many cases, consumers cannot predict a serious injury or medical condition for a given year. Rather than a precise valuation, therefore, a comparison tool should be designed to give consumers a general sense of how OOP costs varies with different plan designs.

This type of comparison tool will help consumers understand any potential tradeoffs between monthly premiums and OOP costs for plans at different metal levels and with different plan designs. This may be particularly important for consumers eligible to receive cost-sharing reductions (CSRs). Consumers eligible to receive CSRs can enroll in a plan variation that may have lower deductibles, coinsurance, and copayments based on household income, but are only

available to eligible consumers that enroll in a silver health plan.[1] Eligible consumers can choose to apply their advanced premium tax credit to a lower-premium bronze plan, as opposed to a silver plan with reduced cost sharing. The comparison tool should help these consumers evaluate the tradeoff between a bronze plan with a lower premium versus a silver plan with a slightly higher premium but cost sharing that may be significantly reduced.

The OOP Cost Comparison Tool is available to consumers shopping for all medical plans in the individual Federally-facilitated Marketplaces as well as individual medical plans in the SBMs whose states utilize the federal platform (https://www.healthcare.gov/see-plans/). Stand-Alone Dental Plans (SADPs) are out of the scope of this comparison tool because the database that CMS is using to develop this tool does not have utilization data and benefit categories applicable to SADPs.

IV.   Data Output and Consumer Display

To aid consumers while comparing health plan options, CMS displays the sum of the OOP cost estimated and premium – calculated on an annual basis. Alongside the estimated total spending, CMS has included a breakout of the premium and the OOP cost estimate as part of the total.

CMS also automatically displays the issuer and consumer portions of total allowed charges for the consumer in a year during which a major accident or illness occurred (high healthcare utilization as described below). This particular display will help to underscore the value of health insurance.

For all OOP cost estimates, CMS will round the values given that this is an estimation tool whose primary purpose is to compare relative cost levels across health plans. Users will also be able to change expected utilization levels and see the consequences in terms of estimated OOP costs across all plans they are considering.

V.   Data Used in the Computations

a. Data Inputs

Our methodology for calculating the OOP cost estimate is based upon three major data inputs: (1) utilization and cost data; (2) the design of a health plan's cost sharing; and (3) user input regarding consumer demographics, such as the number of family members, age, gender, and

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[1] Limited and zero CSR plan variations are available at other metal levels as well. Indians with a household income between 100 -300 percent of the federal poverty level are eligible for a zero cost-sharing plan. Those with a household income below 100 percent of the federal poverty level, and above 400 percent of the federal poverty level, who are not eligible for premium tax credits are eligible to enroll in a limited cost-sharing plan. Regardless of household income, those who enroll in a Marketplace health plan will not have OOP cost for services provided by Indian health programs.

expected healthcare utilization. These inputs are critical to estimating utilization. However, in order to avoid confusion, the consumer-facing portion of the tool will make clear that the tool is an estimator, not used for premium rating purposes, and gender and age are needed for particular types of services because utilization varies by gender and age.

b. Utilization and Cost Data

To provide information on utilization and healthcare costs, we use claims data from MarketScan Commercial Claims and Encounters Database, trended to reflect projected calendar year 2016 data. This commercial database includes detailed enrollment and medical and prescription services utilization information for enrollees who are members of several regional insurers. The database covers approximately 35 million employees, spouses, and dependents in employer-provided health plans that cover a variety of service modes, including preferred provider organizations (PPOs) and health maintenance organizations (HMOs). These claims data are summarized into utilization tables based on age, gender, and utilization level and would be updated annually. The following describes in more detail the methods for constructing these utilization tables.

i. Historical Utilization and Allowed Cost Data Source

The MarketScan Commercial Claims and Encounters Database includes both inpatient and outpatient medical and drug claims coded using multiple procedure codes. Claims account for nearly every healthcare service setting, including physician offices, hospitals, and retail and mail-order pharmacies. Each claim contains detailed payment and charge information. Enrollees in the database are given unique identifiers, so all of one enrollee's claims can be grouped together. Each claim contains detailed demographic information such as age, gender, and geographic location.

ii. Age/Gender Groups

To construct the utilization data for the OOP Cost Comparison Tool, we use the following age groups, for each gender, in the utilization tables:

- 0 to 5 years of age
- 6 to 17 years of age
- 18 to 34 years of age
- 35 to 44 years of age
- 45 to 54 years of age
- 55 to 64 years of age.

These age groups were chosen as they form along natural breaks in terms of healthcare usage: children ages 0 to 5 tend to have higher utilization than children ages 6 to 17, and within the adult age groups each successive group has higher average utilization than the previous one. We

also propose to subdivide these age groups by gender to account for utilization differences by both gender and age.

iii. Benefit Categories

In the OOP Cost Comparison Tool, we use the following benefit categories in the utilization tables:

- Inpatient Facility
- Inpatient Professional
- Emergency Room Services
- Ambulance Trips
- CT/MRI
- Dialysis
- Durable Medical Equipment
- Eye Exams
- J Codes (Injectables)
- Laboratory
- Mental Health
- Preventative
- Primary Care
- Rehabilitation
- Specialist Care
- Outpatient Facility
- Outpatient Surgery
- Diagnostic Cardiology Services
- Ultra Sound
- X-Ray
- Prescriptions - Generic Drugs
- Prescriptions - Preferred Brand Drugs
- Prescriptions – Non-Preferred Brand Drugs
- Prescriptions - Specialty Drugs
- Chiropractor
- Other

The above benefit categories comprise more than 90 percent of total allowed charges in the MarketScan claims data. We model any remaining costs using an "other" category and applying a cost-sharing rate to that category consistent with the average rate of all other benefit categories combined.

iv. Assigning Utilization Levels

To populate the utilization tables, we compute the total annual allowed cost for each beneficiary represented in the data and then divide beneficiaries into 10 deciles within each age and gender group. The first decile represents the 10 percent of beneficiaries with the lowest total allowed costs, and the 10th decile the 10 percent with the highest total allowed costs. For each decile and benefit category combination, we calculate the unit cost, utilization per member per year, and total annual allowed cost based on the claims data. Note that for certain benefit categories, we count multiple utilization units of the same benefit category occurring in a single day as a single utilization unit for the purposes of applying copays.

CMS allows consumers select one of three utilization levels for each family member—low, medium, or high. These levels correspond to specific cost deciles within each age and gender group:

- Low—corresponds to the third decile
- Medium (or Average)—corresponds to the average of the fifth and sixth decile to reflect the median value
- High—corresponds to the tenth decile.

For the consumer-facing portion of the OOP Cost Comparison Tool, we show users what each utilization level (low, medium/average, or high) means in terms of estimated numbers of physician visits, lab tests, prescriptions, and so on. If the consumer does not select a utilization level, the comparison tool will default to medium/average.

Using the above guidelines, we created a summary utilization data set that contains—for each combination of age, gender, decile, and benefit category—an average allowed cost and an average utilization level in terms of visits, prescriptions, hospital days, and so on.

c. Health Plan Cost Sharing Design

i. Plans and Benefits Data

The OOP Cost Comparison Tool uses several data elements from the Plans and Benefits Template[2], including those related to deductibles, maximum out-of-pocket (MOOP) amounts, and copay/coinsurance. The inputs will be structured for all services that are consumed for Tier 1 in-network and the cost-sharing parameters that will be used are values that apply to Tier 1 in-network services. The specific data elements we will use are as follows:

- Deductibles

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[2] The Plans and Benefits Template is provided by healthcare issuers to CMS. It contains data, including plan identifiers, plan attributes, URLs, covered benefits and their limits, and cost-sharing information for health plans offered on the FFMs. Consumers should contact the plan provider directly to ensure services and providers are covered as all information submitted by plan providers is subject to change.

- o Medical, Drug, or Combined Medical and Drug for both the individual and family (six total deductibles).
  - If the In Network Tier 1 deductibles are populated, the comparison tool will use those values; otherwise, it will use the combined in- and out-of-network values.
  - Family deductible for Medical, Drug, or Combined Medical and Drug deductible, and the applicable values for per-person and per-group. The per-person values indicate if a per-person deductible applies for each family member.

- MOOP amounts
  - o Medical, Drug, or Combined Medical and Drug for both the individual and family (six total deductibles).
    - If the In Network Tier 1 MOOP are populated, the comparison tool will use those values; otherwise, it will use the combined in- and out-of-network values.
    - Family MOOP for Medical, Drug, or Combined Medical and Drug MOOP, and the applicable values for per-person and per-group. The per-person values indicate if a per-person MOOP applies for each family member.

- Copays and coinsurance for each benefit category
  - o In Network Tier 1 values for copay and coinsurance.
  - o Applicability of deductibles (from copay and coinsurance descriptions).
  - o Specification if benefit accrues to the in-network MOOP (if benefit is excluded from the in-network MOOP).
  - o Per day or per stay copay descriptors for inpatient facility benefit.

- Other
  - o Maximum Coinsurance for Specialty Drugs
  - o Maximum Number of Days for Charging an Inpatient Copay
  - o Begin Primary Care Cost-Sharing After a Set Number of Visits.

The OOP Cost Comparison Tool maps each of the benefit categories to specific Plans and Benefit Template categories as shown in Table 1 below:

Table 1: Benefit Categories to Specific Plans and Benefit Template Mapping

Comparison Tool Benefit Category	Template Benefit Category (for cost sharing)
Inpatient Facility	Inpatient Hospital Services (e.g. Hospital Stay)
Inpatient Professional	Inpatient Physician and Surgical Services
Emergency Room Services	Emergency Room Services
Ambulance Trips	Emergency Transportation/Ambulance
CT/MRI	Imaging (CT/PET Scans, MRIs)
Dialysis	Dialysis
Durable Medical Equipment	Durable Medical Equipment
Eye Exams	Routine Eye Exam (Adult)
Chemotherapy	Chemotherapy
Laboratory	Laboratory Outpatient and Professional Services
Mental Health	Mental/Behavioral Health Outpatient Services
Preventative	Preventive Care/Screening/Immunization
Primary Care	Primary Care Visit to Treat an Injury or Illness
Rehabilitation	Outpatient Rehabilitation Services
Specialist Care	Specialist Visit
Outpatient Facility	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery	Outpatient Surgery Physician/Surgical Services
Diagnostic Cardiology Services	X-rays and Diagnostic Imaging
Ultra Sound	
X-Ray	
Prescriptions - Generic Drugs	Generic Drugs
Prescriptions - Preferred Brand Drugs	Preferred Brand Drugs
Prescriptions – Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Prescriptions - Specialty Drugs	Specialty Drugs
Chiropractor	Chiropractic Care
Other	*no template benefit mapping (other logic used)*

All of the template benefit categories shown in Table 1 above are included in the Plans and Benefits Template. Most mappings are one-to-one, but in a few instances the OOP Cost Comparison Tool would map a single template category to multiple benefits in the utilization table data.

d. Consumer Input

As discussed above, the OOP Cost Comparison Tool requires consumers to enter the number of family members and the age group, gender, and utilization level for each one. Upon specifying a utilization level, a summary description of that level will be shown, indicating the estimated number of physician visits, lab tests, prescriptions, hospital days, and other care corresponding to that level. Consumers can also alter any input category and compare OOP costs.

VI.   OOP Cost Computation

In the methodology, overall healthcare spending by enrollees and by the plan are governed by a series of threshold constraints on deductibles and MOOP amounts that are reached over time. When each threshold is reached, the methodology will redefine how cost sharing is accrued thereafter.

Specifically, the methodology steps through time (defined as a percentage of total annual allowed cost spending) in a limited number of finite increments until it reaches a spending level of 100 percent. The first increment starts at a spending level of 0 percent and then identifies the lowest spending level at which a member reaches the specified deductible in the given plan design. Once the deductible has been reached, the next increment is determined, which would be the MOOP in the case of self-only health plans.

The methodology becomes more complex for family plans. For example, a family plan would have both a family deductible and a per-person deductible for each member within a family. This plan design introduces several more increments and constraints that must be accounted for in the methodology. In this case, when one family member's deductible is met, the rate of spending against the group deductible would change, because that one family member has satisfied the deductible and is now incurring only post-deductible cost-sharing expenses. Meanwhile, during this increment in the methodology, the other family members would still incur the full cost of services for those covered benefits that are subject to the deductible. During each increment, the model updates the spending level and repeats the process until the spending level reaches 100 percent.