

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OVERSIGHT OF PRIVATE
HEALTH INSURANCE
SUBMISSIONS TO THE
HEALTHCARE.GOV
PLAN FINDER**



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EXECUTIVE SUMMARY: OVERSIGHT OF PRIVATE HEALTH INSURANCE SUBMISSIONS TO THE HEALTHCARE.GOV PLAN FINDER

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WHY WE DID THIS STUDY

The HealthCare.gov Plan Finder is the first comprehensive, online portal that assists consumers in comparing their health insurance coverage options. All private health insurers in the individual and small group markets are required to submit information to populate the Plan Finder. The data collection conducted by the Centers for Medicare & Medicaid Services (CMS) to populate the Plan Finder represents the first national attempt to identify these insurers and the products and plans they offer. To realize the benefits of expanded consumer information, the data displayed on the Plan Finder must be complete and accurate.

HOW WE DID THIS STUDY

We reviewed CMS's policies and procedures, survey responses, and interview responses regarding oversight of insurers' data submissions. We selected a purposive sample of 98 small group products and 94 individual plans displayed on the Plan Finder for its November 2011 and January 2012 updates, respectively. For each sampled product and plan, we identified aberrant or inconsistent data displayed on the Plan Finder and determined whether displayed data were consistent with information provided by insurers' telephone customer service representatives.

WHAT WE FOUND

Most private insurers reported data to the Plan Finder. However, gaps exist in CMS's oversight of private insurers' compliance with Plan Finder reporting requirements. CMS did not conduct targeted followup with insurers that did not report detailed pricing and benefit information. CMS also has not been able to identify the entire population of insurers required to report basic company and product information. In addition, CMS has not asked insurers to certify to the completeness of submitted data in accordance with Federal regulation. CMS implemented numerous strategies to monitor data accuracy. However, the data displayed on the Plan Finder for the sample of products and plans contained some inconsistencies that may confuse consumers. The products and plans displayed were not always available for sale or were not always recognized by insurers' representatives. When products and plans were available and were recognized, 81 percent of their data displayed on the Plan Finder matched the information provided by insurers' representatives.

WHAT WE RECOMMEND

Our findings indicate that additional efforts are needed to oversee private insurers' compliance with reporting requirements for the HealthCare.gov Plan Finder and to ensure that the data displayed on the Plan Finder are accurate. Therefore, we recommend that CMS: (1) establish and implement procedures to identify and pursue private insurers that do not submit required data to the Plan Finder, (2) ensure that each private insurer's Chief Executive Officer or Chief Financial Officer certifies to the completeness of data submitted to the Plan Finder, (3) design and implement additional strategies to ensure Plan Finder data accuracy, and (4) validate that products and plans submitted to the Plan Finder are available for sale. CMS generally concurred with our recommendations and is taking steps to address them.

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OBJECTIVES

1. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) oversees private health insurers' compliance with reporting requirements for the HealthCare.gov Plan Finder.
2. To determine whether selected data displayed on the HealthCare.gov Plan Finder are consistent with other consumer information provided by private insurers.

BACKGROUND

The health care reforms enacted in 2010 seek to increase informed consumer choice by improving Americans' access to information about available health insurance options.¹ Section 1103 of the Affordable Care Act (ACA) requires the Secretary of Health and Human Services to establish a health insurance Web site portal that presents health insurance information in a standardized format and enables comparison of coverage options.^{2,3} Information on coverage options must include private health insurance information, as well as government-administered health insurance information, such as Medicaid, the Children's Health Insurance Program, State high risk pools, and the Pre-Existing Condition Insurance Plan. Data collection and maintenance of the Web site portal, the HealthCare.gov Plan Finder, is managed by the Center for Consumer Information and Insurance Oversight (CCIIO) within CMS.⁴

The Plan Finder is the first comprehensive, centralized, online portal that assists American consumers in comparing insurance coverage options. In addition, the Plan Finder has the potential to increase the sale of private health plans to uninsured individuals and promote market competition to improve health coverage choices for all Americans.⁵ Realizing the benefits of expanded consumer information is contingent upon the completeness

¹ 75 Fed. Reg. 24471 (May 5, 2010).

² The Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152) are collectively referred to as the Affordable Care Act.

³ As specified in 45 CFR § 159.110, health insurance coverage is defined according to section 2791(b)(1) of the Public Health Service Act 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."

⁴ HealthCare.gov is a Federal Web site that contains information about public and private health insurance options across the Nation, connects consumers to quality rankings for health care providers, and explains the provisions and key features of the ACA.

⁵ 75 Fed. Reg. 24481 (May 5, 2010).

and accuracy of the private sector health insurance data populating the Plan Finder. Section 1311 of the ACA requires the Secretary to continue to operate, maintain, and update the Plan Finder.

Although the Plan Finder is not a transactional Web site from which consumers can purchase private insurance, its formats and tools for displaying insurance information can inform State and Federal decisions in the development of Affordable Insurance Exchanges.^{6,7} The Exchanges will serve as competitive marketplaces for consumers to compare and purchase health insurance.⁸ According to HHS, open enrollment in the Exchanges will begin on October 1, 2013. The Congressional Budget Office (CBO) estimates that by 2016, 24 million Americans will receive health coverage through the Exchanges.⁹

The HealthCare.gov Plan Finder

Today, consumers seeking information about private health insurance options are using the Plan Finder as an education tool to find and compare health plans. The Plan Finder was publicly launched on July 1, 2010, and had approximately 2 million visitors from July 2010 to July 2011. As of March 2013, it housed information on more than 8,000 private health insurance products offered within the small group market and the individual market. The individual market sells health insurance to individuals and families seeking coverage, and the small group market sells health insurance to small businesses seeking coverage for their employees.¹⁰

Private insurers were first required to submit data to the Plan Finder in May 2010.¹¹ Since that time, CMS has collected updated information from private insurers multiple times throughout each year. From July to September 2010, the Plan Finder displayed an initial set of basic information on private health insurance companies and their products. For

⁶ Ibid.

⁷ Each State will have an Exchange that is operated by the State, by the State in partnership with the Federal Government, or by the Federal Government.

⁸ ACA § 1321(c) and 77 Fed. Reg. 18310 (March 27, 2012).

⁹ CBO, *Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*, February 2013. Accessed at <http://www.cbo.gov> on March 21, 2013.

¹⁰ 45 CFR § 159.110 adopts the definitions of the terms “individual market” and “small group market” found in ACA section 1304(a)(2) and ACA section 1304(a)(3), respectively. The term “individual market” is defined as the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term “small group market” is defined as the market under which individuals obtain health insurance coverage (directly or through an arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

¹¹ 45 CFR § 159.120(a). The regulation text includes the term “health insurance issuers.” In this report, we use the term “insurers,” rather than “issuers.”

purposes of the Plan Finder, products are defined as packages of benefits that a private insurer offers that have been reported to State regulators in an insurance filing.^{12,13} Each health insurance product may have multiple plan options. Plans may differ in their premiums, cost-sharing options, types of services covered, coverage limitations, and exclusions. The Plan Finder began displaying detailed pricing and benefit information for the individual market in October 2010 and for the small group market in November 2011.

For Plan Finder data collection, storage, and maintenance, CMS contracts with an information technology and business process services firm. According to CMS, the estimated cost of development, operation, and management of the data systems that support the Plan Finder and other HealthCare.gov functions was \$17.2 million for fiscal year 2012.¹⁴

Federal Requirements for Reporting Private Insurance Data

Data Submission Requirements. To populate the Plan Finder, all private insurers must submit data that provide consumers with information on health insurance coverage options.¹⁵ The data submission requirements apply to health insurance sold in both the individual and small group markets in each of the 50 States and the District of Columbia. Private insurers must submit:

- Basic health insurance company and product information, including enrollment data, geographic availability, and Web site links to provider networks. Insurers submit these data electronically to CMS using the Health Insurance Oversight System.
- Detailed pricing and benefit information on premiums, cost-sharing, types of services covered, coverage limitations, and exclusions for each health insurance plan. Insurers submit these data electronically to CMS using the Rate and Benefits Information System.

Insurers must report basic health insurance information prior to reporting detailed pricing and benefit information about their products and plans. For the individual market, the Plan Finder displays detailed pricing and benefit information by health insurance plan. According to CMS, small group market insurers do not generally sell or track pricing and benefit

¹² 45 CFR § 159.110.

¹³ States are primarily responsible for oversight of the private health insurance industry. State regulators ensure that products comply with State law and do not contain major gaps in coverage that might be misunderstood by consumers. CMS does not have the authority to actively solicit State involvement to ensure that products submitted to Plan Finder have been reported to State regulators.

¹⁴ These data systems are used to support other CMS efforts related to ACA implementation in addition to the HealthCare.gov Plan Finder. The Plan Finder is one of several components of the HealthCare.gov Web site.

¹⁵ 45 CFR § 159.120.

information by plan. Therefore, in an effort to reduce insurers' data collection burden, CMS collects and displays detailed pricing and benefit information for the small group market by health insurance product. For a product with multiple plan options, the Plan Finder displays the range of deductible, out-of-pocket limit, copayment, and co-insurance options offered for the plans associated with that small group product.

In addition to current data submission requirements, future releases of the Plan Finder will include performance rating indicators for products and plans, such as the percentage of policies rescinded, the percentage of claims denied, and the number and disposition of appeals.¹⁶ Private insurers are not yet required to submit performance rating indicators.

Data Validation Requirements. Insurers must verify the data submitted to the Plan Finder and make corrections to any errors that are found.¹⁷ In addition, regulations require that each insurer's Chief Executive Officer (CEO) or Chief Financial Officer (CFO) electronically certify to the completeness and accuracy of all data submitted.¹⁸

Related Studies

In 2009, an OIG study identified inaccurate drug prices displayed on the Web-based Medicare Part D plan comparison tool that Medicare beneficiaries use to find, compare, and select Part D prescription drug plans.¹⁹ In response, CMS modified information that appears to consumers regarding the accuracy of the Part D drug cost estimates provided on the Web-based tool.

METHODOLOGY

Scope

We examined CMS's oversight of private health insurers' compliance with Plan Finder reporting requirements and determined whether selected data displayed on the Plan Finder were consistent with other consumer information provided by private insurers. We limited our review to health insurance data reported by private insurers to the Plan Finder—specifically, small group market data that were on display from November 15, 2011, to March 1, 2012, and individual market data that were on display from January 19, 2012, to April 12, 2012. CMS identifies an “insurer” as a private health insurance company operating within a State. For purposes of

¹⁶ 45 CFR § 159.120(f).

¹⁷ 45 CFR § 159.120(e).

¹⁸ 45 CFR § 159.120(g).

¹⁹ OIG, *Accuracy of Part D Plans' Drug Prices on the Medicare Prescription Drug Plan Finder*, OEI-03-07-00600, July 2009.

our review, if a single company operates in 5 States in both the small group and individual markets, we considered it as 10 insurers.

Data Collection

Documentation, Survey, and Interview Data. We obtained current written policies and procedures that CMS uses to oversee private insurers' compliance with Plan Finder reporting requirements. CMS completed two self-administered surveys and responded to in-person interview questions regarding private insurers' data submissions and CMS's oversight activities for the individual and small group markets.

Source Data Populating the Plan Finder Display. We obtained from CMS the source data populating the Plan Finder display for the individual and small group markets. The source data included detailed health insurance pricing and benefit information submitted by 545 small group market insurers and 310 individual market insurers, for a total of 855 submissions.

CMS indicated that it expected 1,026 insurers to submit detailed health insurance information for the Plan Finder update periods in our review. Only 897 insurers actually submitted this detailed information. However, CMS displayed information on the Plan Finder for 855 of these insurers because some insurers' data submissions did not pass CMS's validation process.²⁰

Data Displayed on the Plan Finder. From the Plan Finder, we collected information for selected data fields for 94 individual plans and 98 small group products. Where possible, this purposive sample included products and plans offered by two insurers for each State and the District of Columbia in both the individual and small group markets.^{21, 22} We designed our sample to include a greater proportion of insurers with higher levels of health insurance market share within each State. Of the 192 products and

²⁰ For the November 2011 update of the small group market data displayed on the Plan Finder, CMS provided a source data file on December 12, 2011. For the January 2012 update of the individual market data displayed on the Plan Finder, CMS provided a source data file on February 9, 2012.

²¹ During the review period, the Plan Finder did not display information for any individual market insurers in Rhode Island and displayed information for only one individual market insurer in Alabama, Idaho, Minnesota, Montana, New Hampshire, and Vermont, respectively. Therefore, 94 individual market plans were included in our sample.

²² We initially selected a sample of 102 small group market products. However, for four sampled products, we could not reach a representative during our data collection period who was willing and able to answer our questions. Therefore, our sample included 98 small group market products.

plans in our sample, 122 were offered by insurers with more than 5 percent of their States' market shares.²³

Information Provided by Insurers' Representatives. For each sampled product and plan, we called the insurer's customer service telephone number and asked to speak with a representative who could answer specific questions about products or plans. If transferred by an operator, we considered the person to whom we were transferred to be a "customer service representative." We collected information from these representatives regarding individual plan and small group product data fields displayed on the Plan Finder. Appendix A provides a list of the Plan Finder data fields selected for review.

Analysis

We reviewed and summarized CMS's policy and procedure documentation, survey responses, and in-person interview responses regarding private insurers' Plan Finder data submissions and CMS's oversight activities.

For each product and plan in our sample, we calculated rates of consistency between the data displayed on the Plan Finder and the information provided by insurers' representatives by dividing the number of matching data fields by the total number of data fields included in our review. After calculating a consistency rate for each product and plan, we calculated the average consistency rate across all products and plans.

For each data field under review, we calculated the percentage of products and plans for which the data values displayed on the Plan Finder matched the information provided by insurers' representatives. In some cases, insurers' representatives did not know the answer to or did not answer one or more of the questions asked about sampled products and plans. We did not include missing data values in the denominator when calculating the consistency rate for a product or plan or the consistency rate for a data field.

In addition, we determined whether there were aberrant or inconsistent data values in selected data fields displayed on the Plan Finder for each product and plan in our sample using two different analyses:

- We compared the data displayed on the Plan Finder to the data submitted by insurers to identify any discrepancies.

²³ In measurement of health insurance market competition, 5 percent is considered a threshold signaling that an insurer controls sufficient market share to form provider networks and achieve brand awareness for growth in the future. Kaiser Family Foundation, *How Competitive are State Insurance Markets?*, October 2011. Accessed at <http://www.kff.org/healthreform/upload/8242.pdf> on September 5, 2012.

- We compared the data displayed on the Plan Finder across products and plans to check for extremely high or low values in specific data fields. We also reviewed the Plan Finder display for each product and plan in our sample to identify logical inconsistencies between the values of related data fields. For example, if a plan's data fields for drug coverage indicated that the plan did not cover drugs, but a drug formulary list was included on the plan's display, we would consider this to be an inconsistency between values of related data fields.

Limitations

Although we used randomization where possible to minimize bias in our selection of product and plans, our purposive sample of 192 products and plans is not representative of all products and plans on the Plan Finder display. We also did not validate the information provided by insurers' customer service representatives. Finally, to minimize respondent burden for insurers' telephone representatives, we did not include all data fields for individual plans and small group products displayed on the Plan Finder in our review.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Gaps exist in CMS's oversight of private insurers' reporting of required data to the HealthCare.gov Plan Finder

Thirteen percent of private health insurers that CMS expected to report data did not submit pricing and benefit data to the HealthCare.gov Plan Finder in November 2011 and January 2012. CMS did not conduct targeted followup with these insurers. In addition, CMS has not required insurers to meet the stipulation in the Federal regulation that insurers' CEOs or CFOs certify to the completeness of all submitted data. With respect to oversight of insurers' compliance with reporting basic company and product information to the Department of Health and Human Services (HHS), CMS has not been able to identify the entire population of private insurers required to report.²⁴

Thirteen percent of private insurers did not submit pricing and benefit data to the Plan Finder

Of the 1,026 insurers that CMS expected would report specific pricing and benefit information for the individual and small group markets, 129, or 13 percent, did not submit these data. These 1,026 insurers had submitted basic health insurance information to the Plan Finder in the past and, therefore, were expected to submit detailed pricing and benefit information. Without submitting pricing and benefit data, an insurer cannot be displayed on the Plan Finder. Therefore, during our review periods, there were 129 private insurers with potential health insurance offerings that were not on the Plan Finder. As shown in Table 1, the percentage of insurers that did not submit these detailed data was greater among insurers from the individual market (21 percent) than that from the small group market (7 percent).

Table 1: Private Insurers' Compliance With Requirement To Report Specific Pricing and Benefit Information to the HealthCare.gov Plan Finder

Health Insurance Market	Number of Insurers Expected To Report Pricing and Benefit Data	Number of Insurers That Did Not Report Pricing and Benefit Data	Percentage of Insurers That Did Not Report Pricing and Benefit Data
Individual Market, January 2012 Update	395	84	21%
Small Group Market, November 2011 Update	631	45	7%
Totals	1,026	129	13%

Source: Office of Inspector General (OIG) survey of CMS/CCIIO staff, 2012.

²⁴ 45 CFR §§ 159.100, 159.110, and 159.120.

CMS did not conduct targeted followup with private insurers that did not submit pricing and benefit information to the Plan Finder

CMS did not conduct targeted followup with 128 of the 129 private health insurers that did not report pricing and benefit information for their products and plans. For the small group market, CMS contacted one insurer for failing to submit pricing and benefit information. This insurer indicated that the employee responsible for reporting data to the Plan Finder had been replaced, which led to confusion among staff about data-reporting responsibilities. The insurer indicated that it would report its pricing and benefit information in the next Plan Finder data collection period. For the individual market, CMS did not conduct targeted followup with any insurers that did not submit pricing and benefit information for the January 2012 display period.

CMS has not required insurers to certify to the completeness of the data they submit to the Plan Finder

Each insurer's CEO or CFO must certify to the completeness and accuracy of all data submitted to HHS for display on the Plan Finder.²⁵ However, CMS has not required CEOs or CFOs to certify to the completeness of the data submitted since the launch of the Plan Finder in July 2010. For all Plan Finder data collection periods from July 2010 through January 2012, insurers were required to certify only to the accuracy of the data submitted as a condition of displaying the data on the Web site.²⁶

According to CMS, its decision not to require insurers to certify to data completeness stems from the specification that insurers must submit information on—at a minimum—all plans that are open for enrollment and represent 1 percent or more of the insurer's total enrollment within a ZIP Code. According to CMS, most private health insurers do not track enrollment at the plan level and therefore feel they are unable to certify with certainty that they have submitted all of the plans that represent 1 percent or more of their total enrollment in a given ZIP Code.

²⁵ 45 CFR § 159.120(g).

²⁶ HHS, *Revised Language for CEO/CFO Attestation of CMP [Content Management Portal] Data*, September 22, 2010. Accessed at http://cciio.cms.gov/resources/files/notice_revised.pdf on November 18, 2011.

CMS has not been able to identify the entire population of insurers that are required to report basic health insurance information to the Plan Finder

CMS has not been able to identify the entire population of private insurers subject to the reporting requirement and therefore cannot oversee insurers' compliance with the requirement to report basic health insurance company and product information to HHS. For the November 2011 and January 2012 Plan Finder updates, CMS did not have a mandatory standard process to identify the insurers that may be required to report basic health insurance data to the Plan Finder.

According to CMS, there is no existing reference that it can use to identify the total population of insurers required to report to the Plan Finder. In addition, ambiguity in the insurance market and across States surrounding the definition of a health insurance product makes it difficult for CMS to construct such a reference. However, CMS has made prior attempts to identify insurers subject to Plan Finder reporting requirements using data collected by organizations such as the National Association of Insurance Commissioners, America's Health Insurance Plans, and the Blue Cross and Blue Shield Association.

CMS expects that the introduction of other Federal efforts to collect private health insurance information—including data collections for reviews of insurance rate increases, medical loss ratios, Health Plan Identifiers, and the Affordable Insurance Exchanges—may improve CMS's ability to identify the population of health insurers across the Nation.²⁷

Although CMS implemented numerous measures to oversee data accuracy, the data displayed on the Plan Finder contained some inconsistencies

During the data collection periods for the November 2011 and January 2012 Plan Finder updates, CMS incorporated data quality checks into the data-reporting process for private insurers. CMS held insurers accountable for not resolving identified data quality problems by suppressing their health insurance product and plan information from display on the Plan Finder. Despite these oversight efforts, the data displayed on the Plan Finder for our sample of 192 products and plans

²⁷ A medical loss ratio is the percentage of insurance premiums that an insurer spends on health care services and activities to improve health care quality. The ACA generally requires that insurers spend 80 percent or 85 percent of insurance premiums on health care services and quality improvement. HHS, *Health Insurance Basics: Your Insurance Company & Costs of Coverage*. Accessed at <http://companyprofiles.healthcare.gov/> on March 21, 2013.

contained aberrant or inconsistent values that may be confusing or misleading to consumers.²⁸

CMS employed multiple strategies to monitor data accuracy and held insurers accountable by suppressing data from the Plan Finder display

To oversee data accuracy during the review period, CMS:

- conducted training sessions, held weekly user group calls, and made staff available to help insurers understand how to submit accurate data;
- embedded quality checks into the data entry templates that insurers used to submit their data;
- applied to all submitted data templates an automated system validation process that conducted quality checks and checked that each insurer submitted all necessary data;
- required that insurers review and verify the accuracy of submitted information;²⁹
- conducted post-submission quality checks of four data fields to determine whether the data values appeared as expected;
- tested the Web site links for the brochures, drug formularies, and provider networks submitted by insurers to determine whether the links were functional, direct, and accurate;
- maintained communication channels through the Web site, email, and telephone through which consumers, insurers, and State insurance regulators could inform CMS of potential data errors on the Plan Finder; and
- made the review of insurers' product information available to States' Departments of Insurance through an online data system.

During the review period, CMS suppressed submitted private health insurance data from the Plan Finder display for the following reasons:

- One insurer did not pass the automated system validations applied to submitted data templates. This insurer's data did not progress through the data submission process and therefore were suppressed from the Plan Finder display.

²⁸ The sample of 192 products and plans was selected from source data files provided by CMS. As described on page 5 of the methodology, the files contained detailed pricing and benefit information for 855 insurers displayed on the Plan Finder during our review period (545 small group market insurers and 310 individual market insurers).

²⁹ If the insurer identified errors in the submitted data, CMS instructed the insurer to resubmit and reverify the data.

- CMS suppressed 41 insurers' data from the Plan Finder display because the insurers did not verify the accuracy of submitted data. Of these insurers, 40 operated in the small group market.
- CMS did not display at least 1 link for each of 108 insurers that failed testing on the Plan Finder Web site, but posted a note stating that insufficient link information was provided.
- CMS received two reports, both initiated by State regulators, about potential errors in the small group market data displayed on the Plan Finder. One of these reports led to CMS's suppression of one insurer's data from the Plan Finder display.

Despite CMS's efforts to oversee data accuracy, inconsistencies appeared in the Plan Finder displays reviewed

The Plan Finder included aberrant and inconsistent information that may confuse consumers and undermine the Plan Finder's utility as a consumer education tool. In the sample of products and plans, aberrant or inconsistent data values were associated with 3 data fields on the Plan Finder displays for the small group market and with 13 data fields on the displays for the individual market. One or more of these inconsistencies were reflected on the Plan Finder displays for 127, or two-thirds, of the 192 products and plans reviewed.

- For 89 individual plans, insurers reported to CMS that limitations and exceptions may apply to at least 1 of 9 benefits that are displayed for each individual market plan on the Plan Finder.³⁰ However, for these 89 plans, the corresponding Plan Finder displays indicated that 1 or more of these 9 benefits were "Included Benefits" with no limitations or exceptions.³¹ This systematic inconsistency between the data that insurers submitted to CMS and the data actually displayed on the Plan Finder can be misleading to consumers. For example, a consumer viewing the Plan Finder display for one of these plans may think that the plan fully covers home health care services when the data that the insurer submitted to CMS indicate that this benefit may be restricted in some way.
- For 36 small group products and 17 individual plans, the names of the products and plans that appeared on the Plan Finder display did not

³⁰ The data fields for the nine benefits were: Dental Checkup for Children, Durable Medical Equipment, Eyeglasses for Children, Habilitation, Home Health Care, Hospice, Inpatient Rehabilitation, Outpatient Rehabilitation, and Routine Eye Care for Children.

³¹ Each of these benefits is listed on the Plan Finder display in one of four mutually exclusive coverage categories: "Included Benefits," "Excluded Benefits," "Limited Benefits," or "Benefits Available for Purchase at Additional Cost."

match the names on the insurers' brochures that were linked to the display.³² For some small group products, the entire product name on the Plan Finder display did not appear in the brochure. If consumers cannot identify a product or plan in the insurer's brochure on the basis of the name displayed on the Plan Finder, they may be confused as to whether the product or plan is actually offered by the insurer.

- Seven individual plans had a null value (either "\$0.00" or "No Maximum") displayed in the data field for In-Network Out-of-Pocket Limit, but had specific elements listed as contributing to the out-of-pocket limit in the data field for In-Network Out-of-Pocket Limit Elements.³³ It is unclear why these elements would be listed for a plan without an out-of-pocket limit.
- For four individual plans, all of their drug coverage data fields (Generic Drugs, Preferred Brand Drugs, and Specialty Drugs) on the Plan Finder display indicated that drugs were "Not Covered" by the plan. However, these plans had drug formulary Web site links posted on their displays. It is confusing when a plan that appears to lack drug coverage has a link to a list of covered drugs.
- Three products and plans had extremely low values (\$2,250, \$2,500, \$4,000) displayed in their Annual Maximum Benefit data field. An Annual Maximum Benefit of \$4,000 conveys that the plan pays only \$4,000 for all in-network health care services provided to an enrollee in a year. If this value is inaccurate, it may be misleading to consumers. When other products and plans had an Annual Maximum Benefit listed, the data values ranged from \$25,000 to \$7,500,000.
- Two small group products in our sample had extremely low values (\$1.50, \$2, \$3, \$4, \$5) displayed in the data field for Annual Out-of-Pocket Maximum Options. A value of \$5 conveys the unlikely scenario that the consumer will pay a maximum amount of \$5 for all covered in-network health services during the year. When other small group products in our sample had values listed in this data field, the values ranged from \$200 to \$25,000.

³² We considered a product or plan name on a brochure as matching the name on the Plan Finder display if parts of the displayed name appeared anywhere in the brochure. For example, if part of the displayed name was "1500/30" and cost-sharing information in the brochure included a \$1,500 deductible with 30-percent coinsurance, then we considered the names to match.

³³ The In-Network Out-of-Pocket Limit is the maximum amount a patient pays for in-network covered health services in a year. Generally, this includes the deductible, coinsurance, and copayments. The elements included in the out-of-pocket limit vary from plan to plan.

Not all of the products and plans displayed on the Plan Finder were available for sale or were recognized by insurers' representatives

For 26 of 192 products and plans (14 percent), either the insurers' customer service representatives stated that the health insurance products or plans were not available for sale (14 products or plans) or the representatives could not identify the products on the basis of the name displayed on the Plan Finder (12 products).

Insurers' representatives stated that 14 small group products or individual plans were not available for sale. Of these, 13 were not available at the time of the calls or were not offered in the States or counties that we referred to during the calls. For one individual plan, the representative indicated that the plan was available only to consumers withdrawing from group coverage and therefore was not available to all individuals purchasing private insurance. Insurers' representatives could not identify an additional 12 small group products on the basis of the product names that we provided from the Plan Finder display. For example, one representative said, "There are 10 different [products]—none of them say 'Consumer Choice' on them." Another representative indicated that the product name we gave her was for a "portfolio" and there were multiple products within the portfolio that each included a set of plan options. She said that she could not answer our questions unless we chose a specific product from the portfolio.

We could not compare the data displayed on the Plan Finder to the information provided by insurers' representatives for the 26 products and plans that were not available or could not be identified. Therefore, our data comparisons were limited to the remaining 166 products and plans that were available for sale and recognized by representatives.

Eighty-one percent of product and plan data displayed on the Plan Finder matched information provided by insurers' representatives

On average, products and plans in our sample had 81 percent of the data displayed on the Plan Finder match the information provided by insurers' representatives. We compared information displayed on the Plan Finder to information provided by insurers' representatives for 18 data values for individual plans and 30 data values for small group products.³⁴ To

³⁴ In some cases, insurers' customer service representatives did not know the answer to or did not answer one or more of the questions asked about products and plans in our review. Specifically, insurers' representatives did not know the answer to 5 percent of questions and did not answer 1 percent of questions.

illustrate, if 14 of 18 individual plan data values matched the plan information provided by insurers’ representatives, we calculated a 78-percent consistency rate for the plan.³⁵ The rates of matching data ranged from a 45-percent consistency rate for one small group product to a 100-percent consistency rate for seven products and plans. Overall, small group products had lower rates of consistency than did individual market plans. Table 2 specifies the distribution of consistency rates for the products and plans in our sample.

Table 2: Consistency of HealthCare.gov Plan Finder Display With Information Provided by Private Insurers’ Representatives

Health Insurance Market	Number (%) of Products and Plans With a Consistency Rate of Less Than 75%	Number (%) of Products and Plans With a Consistency Rate of 75–89%	Number (%) of Products and Plans With a Consistency Rate of 90–99%	Number (%) of Products and Plans With a Consistency Rate of 100%	Average Consistency Rate Per Product and Plan
Individual Market, January 2012 Update (86 plans)	9 (10%)	48 (56%)	23 (27%)	6 (7%)	86%
Small Group Market, November 2011 Update (80 products)	38 (48%)	29 (36%)	12 (15%)	1 (1%)	76%
Totals (166 products and plans)	47 (28%)	77 (46%)	35 (21%)	7 (4%)	81%

Source: OIG analysis comparing consumer information provided on calls to insurers’ telephone customer service representatives to the data displayed on the HealthCare.gov Plan Finder Web site, 2012.

For 47 of 166 products and plans (28 percent), less than three-quarters of their displayed data matched the information provided by insurers’ customer service representatives. Small group market products accounted for 38 of the 47. It is important to note that these small group market data reflect CMS’s first collection of detailed pricing and benefit information from small group market insurers. In contrast, individual market insurers have been reporting detailed plan data to the Plan Finder since September 2010.

For certain fields on the Plan Finder display, data values were less likely to match information provided by insurers’ representatives

Across small group products and individual plans, certain benefit data fields displayed on the Plan Finder were less consistent with information provided by insurers’ representatives. For example, only 39 percent of individual plans had data in the Plan Finder’s data field for Home Health Care that matched the home health care benefit information provided by

³⁵ We did not include missing data values in the denominator when calculating the consistency rate. For example, if the representative did not know the answer to 1 of the 18 questions regarding an individual plan and 14 of the remaining 17 data values matched, we calculated an 82 percent (14/17) consistency rate.

insurers' representatives. This low consistency rate may be attributed to the systematic inconsistency described earlier, i.e., insurers reported information to CMS about limitations and exceptions for home health care coverage that was not reflected in the health insurance plan data displayed on the Plan Finder.

For six of the seven benefit data fields that displayed small group products' range of cost-sharing options, less than 75 percent of products had Plan Finder data values that matched the information provided by insurers' representatives.³⁶ Insurers were instructed to summarize information about their products to enter it into the Plan Finder templates. Lower consistency rates for the "range of cost-sharing options" data fields on the Plan Finder display may reflect challenges that insurers faced when summarizing pricing and benefit information as a set of product options. Alternatively, the lower consistency rates for these data fields may reflect challenges that insurers' representatives faced when recalling and presenting the minimum and maximum values of a range of product options.

³⁶ These six data fields were: Available In-Network Deductibles, Available Out-of-Network Deductibles, Annual Out-of-Pocket Maximum Options, Range of In-Network Copay Options, Range of In-Network Coinsurance Options, and Range of Out-of-Network Coinsurance Options.

CONCLUSION AND RECOMMENDATIONS

Private insurers offering health insurance in the individual and small group markets must submit data to populate the HealthCare.gov Plan Finder. The data collection conducted by CMS/CCIIO to populate the Plan Finder represents the first national attempt to identify these insurers and the products and plans they offer. For American consumers to obtain the maximum benefit from the Plan Finder, the private health insurance data displayed there must be complete and accurate.

In November 2011 and January 2012, CMS did not ensure that private health insurers reported all required data to HHS. However, CMS implemented numerous measures to ensure the accuracy of reported data and suppressed data from the Plan Finder when quality checks identified problems. Despite these efforts, our review of the data displayed on the Plan Finder for 192 selected products and plans found that some aberrant and inconsistent data values appeared on the Web site. These inconsistencies may be confusing or misleading to consumers using the Plan Finder to seek information about the private health insurance products and plans available to them.

Our comparison of data displayed on the Plan Finder to data provided by insurers' representatives was designed to identify inconsistencies between two sources of health insurance information. This comparison revealed that some health insurance products and plans displayed on the Plan Finder were not available for sale or were not recognized by insurers' representatives.

When products and plans were available and were recognized, an average of 81 percent of the data displayed on the Plan Finder matched the information provided by insurers' representatives. For a smaller number of products and plans in our purposive sample, less than three-quarters of their Plan Finder data matched the information provided by insurers' representatives. Small group market products accounted for most of these inconsistencies. The data reviewed from the small group market represent CMS's inaugural collection of detailed pricing and benefit information for this insurance market.

Our findings indicate that additional efforts are needed to oversee private health insurers' compliance with reporting requirements for the Plan Finder and to ensure that the data displayed on the Plan Finder are accurate.

Therefore, we recommend that CMS:

Establish and Implement Procedures To Identify and Pursue Private Insurers That Do Not Submit Required Data to the Plan Finder

CMS should establish and implement a standard process to identify private health insurers that are required to report basic health insurance company and product data to HHS. After doing so, CMS should systematically contact insurers that have not submitted basic health insurance information for display on the Plan Finder. CMS has taken initial steps toward this end by seeking a contractor to evaluate Plan Finder data with a specific goal of determining whether the insurers that have reported data to the Plan Finder reflect the entirety of insurers subject to the requirements. In addition, CMS should establish and implement procedures to conduct targeted followup with private health insurers that did not submit pricing and benefit information during each data collection period. If these steps do not improve compliance, CMS should consider seeking additional authority to impose penalties on insurers that do not submit required data.

Ensure That Each Private Insurer's CEO or CFO Certifies to the Completeness of Data Submitted for the Plan Finder

Since July 2010, insurers have been required to certify to the accuracy of the data submitted to the Plan Finder. CMS should implement the requirement in 45 CFR § 159.120(g) that insurers' CEOs or CFOs certify to the completeness of the submitted data as a condition of displaying the data on the Plan Finder. As part of this, CMS may want to consider revising the current specification of completeness—that insurers must submit information on—at a minimum—all plans that are open for enrollment and represent 1 percent or more of the insurer's total enrollment within a ZIP Code. One option is to devise a specification of completeness that aligns with how private insurers track enrollment.

Design and Implement Additional Strategies To Ensure Plan Finder Data Accuracy

CMS incorporates insurer training and data quality checks into the Plan Finder data submission process to prevent and correct data errors. However, our review indicates that CMS should perform additional data quality checks to prevent aberrant or inconsistent values from being displayed on the Plan Finder that may be confusing or misleading to consumers. In designing additional strategies, CMS should begin by addressing the inconsistencies described in this report. For example, CMS should check that data submitted by insurers on limitations or exceptions to plan benefits are reflected on the Plan Finder. CMS may consider incorporating specific instructions in its data entry guidance to private insurers about submitting product and plan names for the Plan Finder that appear on brochures and are

recognizable to insurers' customer service representatives. CMS could also instruct insurers to submit data on the range of cost-sharing options for small group products that are the same as those outlined in materials used by their customer service representatives to sell insurance to small employers.

Validate That Products and Plans Submitted to the Plan Finder Are Available for Sale

Our review indicates that not all private health insurance products and plans that appeared on the Plan Finder were available for sale. CMS is awarding a contract for a Plan Finder data evaluation. One of the goals of this contract is to use data from outside sources to produce a report on insurers' accuracy of reporting. At a minimum, CMS should focus the contractor's efforts on using data from outside sources to ensure that products and plans that are submitted to the Plan Finder are available for sale.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS generally concurred with all of OIG's recommendations and has begun to implement changes to address them. CMS stated that it believes that regulations and standards proposed for 2014 will help simplify the reporting process for health insurers and increase the reliability of Plan Finder information.

CMS concurred with our first recommendation, that it establish and implement procedures to identify and pursue private insurers that do not submit required data to the Plan Finder. CMS stated that it had identified three lists of Health Insurance Issuers that may need to report additional data under the HealthCare.gov regulation and that it would begin sending targeted memos and conducting followup with these issuers in January 2013. In addition, CMS noted that it is compiling lists of issuers required to report to the Plan Finder from other sources and will begin to contact these issuers in the first quarter of 2013.

CMS concurred with our second recommendation, that it ensure that each private insurer's CEO or CFO certifies to the completeness of data submitted to the Plan Finder. CMS stated that it is working to integrate Corporate Officer attestations associated with various ACA reporting requirements. CMS noted that it expects to implement the fuller attestation requirement in the second quarter of 2013.

CMS concurred with our third recommendation, that it design and implement additional strategies to ensure Plan Finder data accuracy. CMS stated that it hired a contractor in 2012 to review the quality of Plan Finder data and provide quarterly reports that will enable CMS to contact issuers regarding aberrant data. In addition, CMS noted that it conducts weekly calls to address questions from issuers on reporting data accurately. CMS stated that it believes that changes to its data collection to reflect the Summary of Benefits and Coverage (a standard document that insurers are required to provide to consumers) will improve communication and presentation of information on the Plan Finder.

CMS concurred with our fourth recommendation, with caveats, that it validate that products and plans submitted to the Plan Finder are available for sale. CMS stated that its data quality contractor will evaluate whether the information reported to the Plan Finder is accurate. In addition, CMS noted that it will encourage the display of "marketing names" for health insurance plans and products to decrease confusion as consumers communicate with sales representatives.

The full text of CMS's comments is provided in Appendix B.

APPENDIX A

Plan Finder Data Fields Included in Office of Inspector General Review of Information Provided by Insurers' Representatives

We collected information from insurers' customer service representatives for 18 of the 55 data fields for individual plans and 23 of the 63 data fields for small group products displayed on the Plan Finder. We included seven small group data fields that each displayed a range of cost-sharing options. For these data fields, we collected information on the minimum and maximum of the range and considered the minimum and maximum as two distinct data values. Therefore, for the 23 selected Plan Finder data fields for small group products, we collected 30 data values from representatives. Table A-1 outlines the Plan Finder data fields included in our review.

Table A-1: Plan Finder Data Fields Included in Office of Inspector General (OIG) Review of Information Provided by Insurers' Representatives

Name of Data Field Reviewed, Small Group Market, November 2011 Update	Name of Data Field Reviewed, Individual Market, January 2012 Update
Product Name	Plan Name
Available In-Network Deductibles ¹	Deductible (Individual)
Available Out-of-Network Deductibles ¹	In-Network Out-of-Pocket Limit (Individual)
Annual Out-of-Pocket Maximum Options ¹	In-Network Out-of-Pocket Limit Elements
Health Savings Account Eligibility	Health Savings Account Eligibility
Annual In-Network Maximum Benefit	Annual Maximum Benefit (Individual)
Doctor Choice	Doctor Choice
Enrollment of Same-Sex Partners	Primary Care Physician Office Visit
Enrollment of Domestic Partners	Specialty Physician Office Visit
Range of In-Network Copay Options ¹	Inpatient Hospital Services
Range of Out-of-Network Copay Options ¹	Emergency Room Services
Range of In-Network Coinsurance Options ¹	Generic Drugs
Range of Out-of-Network Coinsurance Options ¹	Mental Health Coverage (Outpatient)
Specialist Visit	Prenatal and Postnatal Care
Emergency Room	Home Health Care
Generic Drugs	Hearing Aid
Mental [Health,] Inpatient	Long Term Care
Prenatal and Postnatal Care	Chiropractic
Home Health Care	
Hearing Aid	
Long Term Care	
Acupuncture	
Bariatric Surgery	

Source: OIG telephone calls to insurers' customer service representatives based on data displayed on the HealthCare.gov Plan Finder Web site, 2012.

¹ For this small group product data field, we collected data on the minimum and maximum of the range and considered the minimum and maximum as two distinct data values in our analysis.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 14 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Oversight of Private Health Insurance Submissions to the Healthcare.gov Plan Finder"--(OEI-03-11-00560)

The Centers for Medicare and Medicaid Services (CMS) would like to thank OIG for the opportunity to review and comment on the OIG Draft Report referenced above.

The evaluation report issued by OIG identifies several areas where CMS can improve the accuracy and completeness of our data collection to support HealthCare.gov. CMS generally concurs with each of the OIG recommendations and has begun implementation of changes that we believe will meet the recommendations. CMS believes that the overall assessment overstates the problems with the website by underappreciating the degree to which the current insurance market operates in non-standard ways. Current regulation allows issuers to assign a single name to a complex set of options which make it difficult to confirm specifics on the website. CMS does reach out to issuers when errors are reported to us, and these are often the result of misinformation or misidentification by customer service representatives rather than errors in reporting. We believe that regulations and standards currently under review and proposed for 2014 will help simplify this process, and increase the reliability of information.

OIG Recommendation

The OIG recommends CMS establish and implement procedures to identify and pursue private insurers who do not submit required data for the Plan Finder.

CMS Response

The CMS concurs with this recommendation. CMS has identified three lists of Health Insurance Issuers who might need to report additional data under the HealthCare.gov regulation: issuers that have never reported to Health Insurance Oversight System (HIOS) but have greater than zero enrollment and have reported expenses under “major medical insurance” to the National Association of Insurance Commissioners (NAIC); issuers that have reported to CMS, but have lapsed in their reporting; and issuers that have reported at a high level, but who have not provided the detailed data required to appear on the Plan Finder. Targeted memos have been prepared and outreach with follow-up communications will occur in January of 2013. Additionally, CMS has begun compiling lists from other sources than the NAIC and anticipates outreach to those identified in the first quarter of 2013.

OIG Recommendation

The OIG recommends CMS ensure that each private insurer’s Chief Executive Officer or Chief Financial Officer certifies to the completeness of data submitted for the Plan Finder.

CMS Response

The CMS concurs with this OIG recommendation. CMS initially changed the attestation requirements based on feedback from industry and third parties surrounding difficulties in assessing “completeness” of a data submission. We are working to integrate Corporate Officer attestations associated with the various requirements of the Affordable Care Act. Implementation will be integrated with these broader efforts and we expect to implement the fuller attestation requirement in the second quarter of 2013.

OIG Recommendation

The OIG recommends CMS design and implement additional strategies to ensure Plan Finder data accuracy.

CMS Response

The CMS concurs with the OIG’s recommendation. Earlier in 2012, CMS entered into a contract to review the data quality in HIOS and on the Plan Finder. The contractor checks the data against expected results, and will provide quarterly reports that will allow the collection team within CMS to reach out to issuers to correct any aberrant data, allowing for greater accuracy on Healthcare.gov. Data quality is an on-going issue. CMS has had two specific periods in which issuers were specifically encouraged to address general quality concerns. Additionally, weekly calls are held to address specific questions from issuers on how to report accurately. Additionally, CMS believes that some of the attributed “errors” reflect current ambiguities in how products are marketed and reported.

Changes to the collection to reflect the Summary of Benefits and Coverage should allow for more consistent communication and presentation of information. The collection team within CMS is actively working to identify updates and coding changes in order to create a better match between the data collected and that displayed.

OIG Recommendation

The OIG recommends CMS validate that products and plans submitted for display on the Plan Finder are available for sale.

CMS Response

The CMS concurs, with this recommendation, with caveats. As noted, CMS has entered into a contract which will specifically evaluate whether the information reported is accurate. This issue will be addressed in quarterly reports under that contract, starting with the first quarter of 2013. Additionally, CMS has made provisions to begin encouraging the display of “marketing names” for plans and products to decrease confusion as consumers communicate with sales representatives.

The CMS believes the conclusion that plans which are displayed are not available is based on misunderstandings regarding what is reported. CMS addresses these issues as they are identified. For example, we received reports that one plan listed on the web site as available was not for sale in the state identified. The error was not with our data, but was the result of error on the part of the sales representatives from a plan. Additionally, there are numerous examples where options which are available under limited circumstances are not always available under all circumstances. Overall, apparent discrepancies are likely to decrease when a consistent regulatory framework allows for consistent identification of benefits packages and cost sharing options. Generally, misreporting on what can be purchased by a consumer is subject to state level reviews under “false advertising” regulations. CMS has limited authority to pursue this issue.

The CMS appreciates the effort that went into this report and look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Linda M. Ragone, Deputy Regional Inspector General.

Amy Sernyak served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Philadelphia regional office who conducted this study include Joanna Bisgaier and Consuelia McCourt. Central office staff who provided support include Heather Barton, Althea Hosein, Meghan Kearns, and Christine Moritz.

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