

## Coverage Example Calculator Instructions

The Departments developed this calculator for plans and issuers to use as a safe harbor for the first year of applicability to complete the coverage examples in a streamlined fashion; because this approach will be less accurate, it is being allowed as a transitional tool for the first year of applicability. This tool is intended to provide plans and issuers with time to develop accurate methods to populate the coverage examples treatment tables in the summary of benefits and coverage (SBC) template. Plans and issuers will be required to provide comprehensive coverage examples that are based on the coverage information specific to the benefit package no later than January 1, 2014. The calculator allows plans and issuers to input a discrete number of elements about the benefit package. Calculator inputs generally are expected to coincide with the data fields used to populate the front portion of the SBC template. These instructions accompany the coverage example calculator, available at <http://cciio.cms.gov/resources/other/index.html#sbcug>.

To use the coverage calculator, you will need information on the plan's cost sharing, deductibles, and coverage limits for several benefit categories. See <http://cciio.cms.gov/resources/other/index.html#sbcug> for an overview of the inputs required. The coverage example calculator does not require information at the billing code level.

Follow the instructions below to run the coverage example calculator. Data entry fields requiring input are highlighted in orange in the coverage example calculator. The outputs from the calculator can be used to populate the "Plan pays" and the "Patient pays" section of the coverage example in the SBC.

To enable the functions of this calculator, you may need to manually enable the Macros function when you first use this tool.

### **I. Assumptions**

This coverage example calculator makes several important assumptions which will not be accurate for all plan designs. If your plan design differs significantly from these assumptions, the results may be inaccurate. In that case, we make two suggestions. You can alter the coverage calculator to make it more accurate (for example, if your plan covers diabetes supplies under the prescription drug benefit, you can modify the calculator to apply prescription drug cost sharing to those items); or you can design your own coverage calculator.

The coverage example calculator makes the following assumptions:

- The benefit package covers maternity care and diabetes care. If the plan does not cover one or both of these benefits categories, the coverage example calculator cannot be used for the non-covered benefit;

- All items and services in the maternity and type 2 diabetes scenarios<sup>1</sup> are covered by the benefit package, unless otherwise indicated by the plan or issuer with the exception of the following:<sup>2</sup>
  - Over-the-counter drugs and alcohol swabs are not covered; and
  - Birthing education classes are not covered;
- All items and services are subject to the overall deductible, unless they are subject to a separate deductible;
- All items and services count toward the overall plan deductible, except those subject to separate deductibles;
- Any applicable deductibles must be met before the patient is charged copayments or coinsurance;
- All cost sharing (all deductibles, copayments and coinsurance amounts) counts toward the out-of-pocket limit, except for the services that are not covered by the benefit package or assumed not to be covered by the calculator (see above);
- Diabetes education (codes 98960 and 97803) is treated as Visits and Procedures, meaning that it is subject to the overall deductible and is subject to the physician cost sharing;
- If a copayment is greater than the allowed amount, the patient is charged the allowed amount. For example, if the lab copayment is \$15 but the lab allowed amount is \$7.00 then the patient pays \$7.00;
- Items and services in the diabetes scenario labeled “Medical equipment and supplies” are considered durable medical equipment (DME) and treated under the DME benefit; and
- All covered prescription medications are subject to the generic medication cost sharing level.
- For the maternity scenario inpatient stay, the copayment or coinsurance amount is applied one time for all three inpatient services in the scenario. If the plan design would apply multiple cost sharing amounts (e.g. a copayment for each inpatient service listed in the scenario), enter the total applicable amount (not the per service amount) in the input field.

## **II. Starting Screen**

From the “Starting Screen,” select whether you would like to import data from a Comma Separated Value (.csv) file or enter benefit package data manually. Click “Let’s Get Started.” You will need to enable macros to continue.

If you select manual entry of benefit package data, you will enter the information described below for each benefit category listed. The outputs will be specific to that benefit package. If

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<sup>1</sup> The complete lists of items and services for each scenario – and that the coverage calculator assumes are covered – are available at <http://cciio.cms.gov/resources/other/index.html#sbcug>.

<sup>2</sup> Note that the coverage example calculator does allow plans and issuers to indicate that specific categories of care are not covered.

you choose the automatic entry option, you will input a .csv file with the values in a specified order. That order is described below.

### **III. Entry Screens**

#### **Cost sharing**

For each of the coverage categories, select whether a copayment or coinsurance applies from the drop-down menu in column J and enter the corresponding value in column L. For example, if the copayment amount is \$10, you would select “Copayment” and enter “10.” If the coinsurance rate is 30%, you would select “Coinsurance” and enter “30.” Do not enter a dollar symbol or a percentage symbol into column L. If a coverage category is subject to the deductible, but no other cost sharing, select “Coinsurance” and enter “0”<sup>3</sup>.

If a copayment or coinsurance does not apply, select “No cost sharing” from the drop-down menu. If a category is not covered, select “Not covered.” Selecting “No cost sharing” means that the plan will be charged the entire allowed amount for a service; selecting “Not covered” means that the patient will be charged the entire amount for a service and that the service will be treated as excluded (will not count toward deductible or out-of-pocket limit). If you select either “No cost sharing” or “not covered” leave column L blank.

For Routine obstetric care, in the drop down menu you must select whether “Copayment,” “Coinsurance,” “Deductible,” “No cost sharing,” or “Not covered” applies. Unlike the other benefit categories, you can only select one cost sharing option for this benefit to incorporate the assumption that only one form of cost sharing can apply to this bundled service. If your coverage has a benefit specific deductible applicable to routine obstetric care, select “Deductible” in column J then enter the deductible amount in column L. This dollar amount will also appear in column L, line 20.

The coverage categories include the following:

- Durable medical equipment and supplies (DME)
- Prescription drugs (generic)
- Hospital inpatient and anesthesia
- Laboratory tests
- Radiology (ultrasounds)
- Routine obstetric care (prenatal and postnatal care)
- Visits and procedures (physician services)

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<sup>3</sup> This would apply if a plan covers a category of care with no cost sharing after the patient has met a deductible. For example, if a patient must pay 100% of the cost for DME prior to meeting a \$500 deductible, and after the deductible has been met, the plan will pay 100% of the cost for DME.

## Vaccine and other preventive services

### **Out-of-pocket limit**

Enter the annual out-of-pocket limit for the plan or coverage. For family coverage with separate out-of-pocket limits for each individual and the family, enter only the per-person out-of-pocket limit. If the plan or coverage does not have an out-of-pocket limit, leave this entry blank.

### **Deductibles**

Enter the dollar amount for each deductible category. If a deductible does not apply, leave the cell blank. For family coverage with separate deductible amounts for each individual and the family, enter only the per-person deductible.

The deductible categories include the following:

- Overall deductible
- Other separate deductibles
  - Durable medical equipment (DME)
  - Prescription drugs (generic)
  - Hospital inpatient and anesthesia
  - Routine obstetric care (prenatal and postnatal care)
  - Vaccines and preventive

### **Coverage limitations**

Enter a value for the limits on the number of items and services described below. Enter the limits that apply either per month or per year, as applicable. For example, if the benefit package limits an individual to two items of DME per year, enter the number 2. If no limits apply or an item or services is not covered, leave blank.

- Generic prescriptions per month
- Generic prescriptions per year
- Durable medical equipment per month
- Durable medical equipment per year
- Visits and procedures per year

Click “Run the Calculator” once you have entered all the information.

If you select automated entry, you must create a .csv file with variables in the correct order and formatted correctly to interact with the model. The variable order matches the input order in the manual input page of the coverage example calculator.

As the screen shot below shows, the first variable is the plan cost sharing type for DME (Column A); in Column B, the cost sharing amount is entered. The order follows for the remaining 7 cost sharing questions, then for the out-of-pocket amount, the applicable deductibles, and the applicable limits.

The following fields need to be separated by commas or in separate cells (each plan on one line):

DME Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

DME Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Generic RX Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Generic RX Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost sharing or Not Covered (still requires comma separation to indicate blank)

Hospital Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Hospital Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Laboratory Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Laboratory Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Radiology (Ultrasound) Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Radiology Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Routine Obstetric Care (Bundled) Selection: Copayment, Coinsurance, Deductible, No Cost Sharing, Not Covered

Routine Obstetric Care (Bundled) Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No-Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Vaccine & Preventive Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Vaccine & Preventive Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Visits & Procedures Selection: Copayment, Coinsurance, No Cost Sharing, Not Covered

Visits & Procedures Value: Dollar if Copayment, Decimal if Coinsurance (i.e. 0.15), Zero (“0”) if only deductible applies, Blank if No-Cost Sharing or Not Covered (still requires comma separation to indicate blank)

Out-Of-Pocket Limit: Dollar value, Blank if No Out-of-Pocket Limit applies (still requires comma separation to indicate blank)

Overall Deductible: Dollar value, Blank if No Overall Deductible applies (still requires comma separation to indicate blank)

DME Deductible: Dollar Value, Blank if No DME Deductible applies (still requires comma separation to indicate blank)

Prescription Drugs (generic) Deductible: Dollar Value, Blank if No Prescription Drug (generic) Deductible applies (still requires comma separation to indicate blank)

Hospital Inpatient and Anesthesia: Dollar Value, Blank if No Hospital Inpatient and Anesthesia Deductible applies (still requires comma separation to indicate blank)

Routine Obstetric Care (Prenatal and Postnatal care) Deductible: Dollar Value, Blank if No Routine Obstetric Care Deductible applies (still requires comma separation to indicate blank)

Vaccines and Preventive Deductible: Dollar Value, Blank if No Vaccine and Preventive Deductible applies (still requires comma separation to indicate blank)

Generic Prescriptions Limit per Month: Number of limits, Blank if No Limits apply (still requires comma separation to indicate blank)

Generic Prescriptions Limit per Year: Number of limits, Blank if No Limits apply (still requires comma separation to indicate blank)

DME Limit per Month: Number of Limits, Blank if No Limits apply (still requires comma separation to indicate blank)

DME Limit per Year: Number of Limits, Blank if No Limits apply (still requires comma separation to indicate blank)

Visits and Procedures Limit per Year: Number of Limits, Blank if No Limits apply (still requires comma separation to indicate blank)

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	
1	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	5000	1000	250	
2	Copaymer	15	Copaymer	15	Copaymer	15	Copaymer	15	Copaymer	15	Copaymer	15	Copaymer	15	Copaymer	15	5000	1000	250	
3	Not Covered		No Cost Sharing	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	Coinsuran	0.15	1000		250
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#### IV. Results

##### Manual

If you use the manual entry option, the coverage example calculator will apply your inputs to each of the treatment scenarios (maternity and type 2 diabetes). For each scenario the calculator will apply the applicable deductible and cost sharing information for the benefit package option to each line item in chronological order. The coverage example calculator will generate final results for each of the following:

Plan Pays: [Total amount the plan or insurer pays over the course of the scenario]

Patient Pays:

Deductibles [total the patient would pay towards deductibles]

Copayments [total the patient would pay in copayments]

Coinsurance [total the patient would pay in coinsurance]

Exclusions & Limits [total the patient would pay due to exclusions in coverage and limitations on covered benefits]

Total, excluding Premiums [total the patient would pay over the course of the scenario]

The coverage example calculator will round the total cost for the Patient Pays results to the nearest ten dollars for each cost sharing category (Deductible, Copayment, Coinsurance, Limits & Exclusions, and Total). For example, if the total copayment amount is \$67, it will be rounded to \$70 in the Patient Pays results. The total amount for the Plan Pays results is calculated by subtracting the total amount the patient pays from the total allowed amount for the scenario.

Below is a screenshot of the output. The results may be added to the coverage example tables in the SBC.

Re-run Calculator:

**MANUAL ENTRY RESULTS**

Maternity Scenario		Diabetes Type 2 Scenario	
Plan Pays:	\$5,450	Plan Pays:	\$3,610
Patient Pays:		Patient Pays:	
Deductibles	\$520	Deductibles	\$800
Copayments	\$190	Copayments	\$700
Coinsurance	\$1,230	Coinsurance	\$210
Exclusions & Limits	\$150.00	Exclusions & Limits	\$80
<b>Total, excl Premiums</b>	<b>\$2,090</b>	<b>Total, excl Premiums</b>	<b>\$1,790</b>

Automated

The .csv file that is the output will contain the plan benefit design information that was in the .csv input file, but with additional variables, that correspond to the outputs above. Note: you



may see an error “results file with the same name is already open,” however your results will be available following the last column in the input sheet, usually column “AD”.

The output file keeps the input values and adds the following additional results fields for each line (same order as on the manual results tab):

Maternity <scenario identifier>

Plan Pays: Dollar value

Deductibles: Dollar value

Copayments: Dollar value

Coinsurance: Dollar value

Exclusions & Limits: Dollar value

Patient Pays Total, excl Premiums: Dollar value

Diabetes <scenario identifier>

Plan Pays: Dollar value

Deductibles: Dollar value

Copayments: Dollar value

Coinsurance: Dollar value

Exclusions & Limits: Dollar value

Patient Pays Total, excl Premiums: Dollar value

## **V. Rules for Using this Transitional Coverage Example Calculator**

This coverage calculator is not accurate for and may not be used by plans that put annual dollar limits on essential health benefits.

This coverage calculator is not accurate for and may not be used by plans that pay a fixed dollar amount per day or period (referred to as fixed indemnity) for any categories of care that appear in either the maternity or diabetes scenarios.

Plans and issuers may modify this calculator to the extent that it results in an estimate that more accurately reflects cost sharing responsibility for patients. Plans and issuers may make no

alterations to this calculator under the safe harbor that lessen the accuracy of the estimate of patient cost sharing responsibility. Through the Macros tab in the toolbar of the spreadsheet, users may view and alter the model logic to better reflect actual plan design.