CLEAR CHOICES
A MOVEMENT FOR INFORMED HEALTH CARE

May 29, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-10558
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

RE: Information Collection for Machine Readable Data for Provider Network and Prescription Formulary Content for FFM QHPs

Dear Mr. Slavitt,

The Clear Choices Campaign is pleased to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding Information Collection for Machine Readable Data for Provider Network and Prescription Formulary Content for FFM QHPs, published in the Federal Register on March 30, 2015 (File Code CMS-10558).

Clear Choices is a consumer-industry coalition dedicated to making health markets more transparent, accountable, and consumer-friendly. Clear Choices is committed to ensuring patients have access to relevant and meaningful information, so they can make informed decisions about their health care and health coverage. We believe doing so will not only empower consumers, but also improve quality, improve health outcomes, and lower health costs. Realizing this potential will require the broader availability and use of information and data to generate meaningful and accurate comparative information on health plan and provider choices.

We are pleased that the proposed rule works to improve the information available prior to a consumer's enrollment in a health plan. We believe that CMS should take additional steps to ensure that robust information is available to consumers to improve the operation of competitive markets. Our comments on the proposed rule are outlined below.

General Comments

Sections 156.122(d)(1)(2) and 156.230(c) of the Final Notice of Benefit and Payment Parameters for 2016 (CMS-9944-F) established new requirements for qualified health plan (QHP) issuers in the Federally-Facilitated Marketplace (FFM) to submit provider and formulary data in a machine-readable format to the Department of Health and Human Services (HHS) and for posting on issuer websites. The requirements are intended to promote greater transparency by allowing software developers to use the provider and formulary data to create innovative consumer facing resources that help prospective enrollees make more informed decisions about their health coverage. CMS has issued an information collection request (CMS-10558) in connection with these new requirements.

Clear Choices strongly supports the requirement for machine-readable provider and formulary data, as expressed in our comment letter on the proposed 2016 Notice of Benefit and Payment Parameters.[1] Currently, consumers can only view provider networks and formularies for QHPs on a one-off basis, which is highly inefficient and largely ineffective. In addition, there is little ability for consumers to compare provider networks and formularies across different QHPs through the insurance exchange websites or through third-party tools.

In contrast, requiring standardized, machine-readable provider and formulary data would lay the groundwork for establishing a user-friendly means for consumers to search or compare QHPs that cover their preferred providers and drugs. Similar requirements for machine-readable directories already apply for Medicare Part D and the Medicare.gov website allows prospective enrollees to compare plans based formulary lists tailored to their particular needs. As in Medicare, we strongly encourage CMS to consider developing stronger data and tools for consumers shopping for coverage through the insurance exchanges. We believe that giving patients the ability to compare plan features effectively is critical to ensuring they select plans that best meet their needs.

Further, we support the innovation opportunities and potential for widespread development of third-party consumer-oriented tools created by this proposed requirement to help promote transparency and more informed consumer choice. After decades of languishing at the back of the pack in terms of IT adoption, the health sector is investing heavily in a new infrastructure of secure health records and communication systems. Advances in big-data analytics are dramatically expanding our capacity to process data in ways that generate actionable, real-time insights with respect to both the efficacy of cures and efficiency of care delivery. Producing comparison tools via machine-readable formulary and provider directories creates new opportunities to drive market efficiencies through more competitive insurance exchanges. We strongly support the CMS proposal to require submission of the data in this machine-readable format.

Recommendations

As CMS moves to operationalize this proposal, we recommend that the agency incorporate the following guidance into the Developer Documentation requirements for information plans must submit. These clarifications will help ensure that the provider and formulary data files are robust, comprehensive, and usable for third-party organizations seeking to build consumer-oriented plan comparison tools.

1) **Strengthen Requirements to Denote Application of a Deductible:** The "Plans.json" file contains fields for copay and coinsurance options (field names: copay_opt, coinsurance_opt, listed on pages 3 and 4) in the cost sharing sub-type section. The fields contain qualifiers for the copay and coinsurance options with values such as AFTER-DEDUCTIBLE, BEFORE-DEDUCTIBLE, NO-CHARGE, and NO-CHARGE-AFTER-DEDUCTIBLE. These qualifier values are listed as non-required fields (i.e., "No" in the column for Required).

    a. To prevent any unnecessary confusion on the application of a deductible to patient cost sharing, this field should be changed to a required field (i.e., change the value in the Required column for this field from "No" to "Always"). Deductible requirements for prescription drugs are a widespread issue for consumers. For example, in 2014,

[1] Clear Choices Campaign, Letter to Department of Health and Human Services Secretary Sylvia Mathews Burwell, "Re: HHS Notice of Benefit and Payment Parameters for 2016." 22 Dec 2014. http://www.clearchoicescampaign.org/s/2016-NBPP-clear-choices-draft-letter-final.pdf

63 percent of Silver plans and 83 percent of Bronze plans available through the insurance exchanges subjected some or all drugs to a plan deductible.[2] It is critical that consumers always receive accurate information of how a plan deductible may affect their prescription drug cost sharing in the formulary data.

b. In addition, if a plan enters a copay or coinsurance as "BEFORE-DEDUCTIBLE," the tool should trigger the plan to include a copay or coinsurance as "AFTER-DEDUCTIBLE" to ensure comprehensive data are included. For plans that have flat copay cost sharing that apply irrespective of the deductible (e.g., $10 copay for generic drugs), CMS should consider including a "NOT-SUBJECT-TO-DEDUCTIBLE" or "NOT-APPLICABLE" qualifier as well (under the copay_opt and coinsurance_opt field names). These changes will help ensure that all plan formulary data is reported accurately for the varying types of cost sharing consumers may face.

2) **Clarify Requirement for Direct URL to the Summary of Benefits and Coverage:** The "Plans.json" file includes a field in the schema sub-section for the direct URL to the Summary of Benefits and Coverage and indicates that the link is required. However, this entry is the only field to use the word "Yes" to show it is required rather than the word "Always." CMS should either clarify the distinction between "Yes" and "Always" for this purpose or use only one term, if the words are synonymous. We believe this will minimize confusion and lead to fewer submission errors.

3) **Allow Plans to Report Multiple Tiers of Cost Sharing:** The "Plans.json" file does not include any means to capture tiered cost sharing within a plan's in-network drug tier. Many plans include both Tier 1 and Tier 2 cost sharing for prescription drugs within their SBCs. For example, a plan may denote "Specialty Drugs, In-Network, Tier 1: "$100 copay after deductible; Tier 2: 20% coinsurance after deductible." Without clarification, most plans are likely to report just the Tier 1 cost sharing, which may result in inaccurate information for certain consumers viewing the formulary data. CMS should require plans to include multiple tiers of cost sharing for prescription drugs, as applicable.

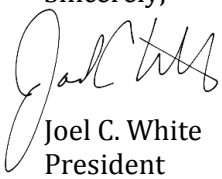
4) **Provide Further Detail on the Provider and Formulary Data System:** CMS should provide additional details in advance on the software system the agency will utilize to process the provider and formulary data, to ensure that plans have sufficient time to organize their data in an optimal format for submission.

[2] Breakaway Policy Strategies, "The New ACA Health Insurance Exchanges." Jan 2014. http://www.phrma.org/sites/default/files/pdf/aca-exchanges-breakaway-report.pdf#page=5

Conclusion

Thank you for the opportunity to comment on the proposed rule. Clear Choices strongly supports CMS efforts to improve health care transparency, including the proposal to require machine-readable provider and formulary data for QHPs in the FFM. To maximize its benefits for consumers, we urge CMS to include the recommendations offered in this comment letter in the agency's final guidance for implementation of the new requirements. We look forward to continuing to work with CMS to ensure that all stakeholders and consumers have access to the information they need to make better health care choices.

Sincerely,



Joel C. White
President