BlueCross BlueShield Association

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Centers for Medicare & Medicaid Services,
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10572
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

Submitted via http://www.regulations.gov

SUBJECT: Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS–10572)

Dear Sir/Madam:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments in response to the Centers for Medicare and Medicaid Services ("CMS") proposed information collection, "Transparency in Coverage Reporting by Qualified Health Plan Issuers," [CMS-10572] released by CMS on August 12, 2015.

The Blue Cross Blue Shield Association is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 105 million members – one-in-three Americans. Blue Cross and Blue Shield Plans offer coverage in every market and zip code in America. Plans also partner with the government in Medicare, Medicaid, and the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

We continue to support CMS' proposal to utilize a phased approach for implementing Transparency in Coverage requirements in section 1311(e) of the Affordable Care Act ("ACA"). The phased approach will provide CMS with an opportunity to develop best practices for providing the transparency in coverage information in a meaningful way that will assist consumers in making informed decisions regarding their coverage options, ensure data is accurate, and minimize confusion.

Overall, we strongly support the proposed approach of streamlining the data collection by relying on existing data sources already in the public domain, thereby minimizing duplicative data collection. The transparency in coverage requirements should continue to be implemented so that the administrative burden on health plans does not outweigh the value provided to consumers. Further, data should be displayed to consumers in a useful and meaningful manner

that will assist a consumer in selecting coverage that meets his or her needs. However, CMS should avoid displaying data that may create competitive issues that undermine the stability and affordability of the market.

BCBSA offers the following detailed recommendations on the proposed Transparency in Coverage data collection:

Submission and Display of Data

Issue: CMS proposes that for the initial data collection, issuers will report required data to an email address set up by CMS for collecting Transparency in Coverage data. However, CMS does not specify how the agency will ensure the security of reported data during the submission process.

Recommendation: BCBSA recommends that CMS implement controls to ensure the secure transfer of data.

Rationale: An open email address may lead to potential data integrity issues, including entities pretending to be QHP issuers submitting falsified information, which would lead to inaccurate and misleading information displayed to consumers.

Elements for Display

Periodic Financial Disclosures

Issue: CMS proposes to display prior calendar year issuer-level information about premiums, assets, and liabilities that the NAIC currently collects and displays on its website.

Recommendation: We support the proposal to link to an existing NAIC website displaying issuer-level periodic financial information.

Rationale: BCBSA supports leveraging data NAIC already collects and displaying a direct link to the NAIC Web page where these data reside. We are concerned that pulling the data from NAIC Website for display on Healthcare.gov may increase the chances for potential data issues, including errors in simply transferring the information, and misinterpretation or incorrect display of existing state-reviewed financial information.

Data on Enrollment

Issue: CMS proposes displaying issuer-level enrollment data as derived by the FFM. The enrollment data displayed will be based on the end of calendar year's information. CMS does not provide detail about the approach for SBMs using the federal IT platform. CMS alludes to a future PRA for collecting data on "disenrollments" which is addressed in a subsequent recommendation below.

Recommendation: BCBSA supports CMS' proposal to provide enrollment data at the issuer level but recommends that CMS provide a disclaimer that an end of calendar year number, like any snapshot in time, does not provide a full picture regarding issuer enrollment. CMS should also explain what the data represent, so consumers understand whether the information is net of disenrollments, and whether the data only reflect everyone that paid and effectuated coverage or all enrollments.

Rationale: Enrollment data fluctuate throughout the year for a number of reasons, including changes in circumstances leading to special enrollment periods, non-payment of premiums by enrollees, data mismatch inconsistencies, and a host of other reasons. This means that an end of calendar year enrollment number will be a "snapshot" in time, and unless that is clarified, it will not provide a fully accurate picture for consumers on what the data represent.

Data on Rating Practices

Issue: CMS proposes posting data on rating practices based on plan-level URRT data already posted on data.healthcare.gov rather than creating a new data collection.

Recommendation: BCBSA supports relying on existing data submitted through the URRT but recommends that the data not be made available until after the completion of the QHP certification process. BCBSA also recommends that CMS ensure that no proprietary or confidential information is released to the public.

Rationale: While we support avoiding duplication of data collection requirements, there are elements of the URRT data that are not generally made public and are proprietary in nature. If the information is displayed prior to rates being made available to the public, then competitive issues will arise that will affect the stability and affordability of coverage in the market.

Data on Claims Denials and Disenrollment

Issue: CMS alludes to future PRA packages containing additional data elements, such as data on claims denials, including reason codes, and data on disenrollment, including reasons for disenrollment.

Recommendation: BCBSA recommends that CMS not display additional data elements until the existing exchange processes are stabilized and until CMS has worked with stakeholders to determine what data will be most valuable to consumers. BCBSA also recommends that CMS develop common definitions to ensure the data collected are accurately represented. The definitions and other data requirements should be made available well in advance of any issuer reporting requirement, as significant programming effort may be required.

Rationale: As noted earlier, BCBSA supports providing data that are useful and meaningful to assist consumers in selecting quality and affordable coverage. However, data elements considered for future collections are not self-explanatory, and may not be useful to consumers unless revised or further defined. For example, the ACA requirement to display "number" of denied claims, should be collected and displayed as a percentage because it would be more useful to consumers. Moreover, there are dozens of reasons that a claim may be denied that do not represent a final denial for payment (errors in completing claim forms, requests for additional information, etc.). Also, claim denials where another party was responsible (COB situations) should not be counted as denials.

Other information as determined by the Secretary

Retroactive Denials

Issue: CMS proposes that issuers provide information on retroactive denials that explains that claims may be denied retroactively, after the enrollee has obtained services from the provider.

Recommendation: BCBSA recommends that CMS change the retroactive denial category to claims denials.

Rationale: Almost all coverage determinations for all claims, other than claims that are paid at the point of service such as pharmacy claims, are made after the services have been rendered. Categorizing the policy as retroactive denials suggests that a payment has been made for a service for which an issuer has subsequently changed the determination.

Timing of Data Collection

Issue: CMS proposes that the data collection will start in 2016.

Recommendation: BCBSA recommends that CMS clarify when issuers are required to have the links to the required information go live for the general public. For the collections proposed in this PRA, CMS should release the specifications for the final Transparency in Coverage data collection with sufficient time for issuers to compile the necessary information and develop and test the IT systems needed to post the required data.

Rationale: As stated earlier, it is necessary to have the specifications well in advance of any issuer reporting requirement because issuers need time to compile the required information and develop and test new IT systems to support the display of the information.

Thank you for your consideration of our comments. If you have questions about comments, please contact Noah Isserman (noah.isserman@bcbsa.com or 202.626.8621).

Sincerely,

Kris Haltmeyer
Vice President, Health Policy and Analysis