



October 13, 2015

To: Office of Strategic Operations and Regulatory Affairs, Division of Regulations
Development, Centers for Medicare & Medicaid Services

Re: Information Collection: Transparency in Coverage Reporting by Qualified Health Plan
Issuers, CMS-10572, OMB Control Number: 0938-New

Families USA is a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality health coverage and care for all. We are writing to provide comments in response to CMS's intention to collect data under CMS-10572 Transparency in Coverage Reporting by Qualified Health Plan Issuers. Data displayed under sections 2715A and 1311(e)(3)(A) of the ACA are critical for consumer shopping and to help regulators assess whether plans are complying with consumer protection standards they are required to meet by law.

While the current guidance is a step forward in providing health plan transparency for consumers, implementation of Sections 2715A and 1311(e)(3)(A) are years delayed and much of this guidance is still not in accordance with the standards established in the Affordable Care Act. The data collection cannot be considered to meet consumers' legal rights to transparent information on health plans if it excludes specific elements required by the Affordable Care act and does not comprehensively implement others. We therefore recommend modifying the guidance to provide a timelier implementation of Sections 2715A and 1311(e)(3)(A), a clear framework for presenting the information in a consumer-friendly manner, a greater emphasis on the use of the data collection for oversight purposes, and some specific modifications to how certain data elements are collected and made transparent. We appreciate you considering our comments.

Phased-In Approach

The ACA established an effective date for Section 2715A of September 23, 2010. The law set an effective date of January 1, 2014 for Section 1311(e)(3)(A), in conjunction with the opening of the law's insurance exchanges. Given the delayed release of this guidance, along with the phased-in approach to implementation of these requirements that it proposes, which will further prolong the availability of transparent health plan data, we are concerned about consumers' delayed access to this information.

Although we understand that there may be IT updates necessary for collecting some of the required data collection elements, the delay has allowed issuers to leave consumers uneducated about health plan practices and policies and to leave regulators without adequate oversight ability of critical plan practices including claims denials and other factors that could indicate problems with plans, such as high levels of disenrollment or out-of-network claims. We believe it is critical that consumers and regulators have this information as soon as possible for their plan selection and oversight needs.

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Recommendation: We recommend that all ACA-compliant individual and small group health plans, not just those that are sold in the through the federally facilitated marketplace (FFM) or in states that use FFM technology, be required to comply with sections 2715A and 1331(e)(3)(A) of the ACA immediately. HHS should modify the guidance to include a clear timeline for compliance among fully insured large group plans and self-insured plans.

An important near-term step that CMS could take to extend data reporting beyond these plans would be to require basic reporting about so-called grandmothers plans – those that were permitted to continue covering individuals and groups for a limited period of time without being required to comply with ACA market reforms that would otherwise apply. These plans are expected to phase out over the course of the next two years in the states where they have been allowed to continue. CMS should collect information in 2016 about the number of such plans and the number of lives they cover.

Submission and Display of Data

We support the requirement in the guidance that plan information under these collection requirements will display in a unique location on healthcare.gov where the data will be aggregated at one spot. However, we remain concerned about ease of information access for consumers. While we appreciate that healthcare.gov will provide a centralized landing page to direct the public to the health plan data they seek, we are concerned with the simplicity and accessibility of data when they will be displayed via separate linked web pages and whether they will sufficiently serve the goal of making data on various plans transparent and comparable for the public.

Recommendation: We urge HHS to prioritize the creation of a dynamic format for displaying health plan data and a uniform method of presentation that does not require the public to visit multiple locations to access all of the information (i.e. follow multiple links). We believe that, in general, plans should submit data at least quarterly and information on display should be the most recent information received by CMS.

Data Elements for Display

Claims Payment Policies and Practices: In addition to the content required in this section of the guidance, for each product issuers should be required to indicate whether there are any unique design features for the given product such as wellness programs, value-based insurance design, tiered, narrow, or value-based insurance networks, reference pricing, or other benefit designs that may impact the way claims for services are paid or the way costs of a claim are distributed between the issuer and the enrollee in a specific product. For these features, explanations for how the cost structures/ differentials work, with dollar amounts, should be included.

Data on the number of claims that are denied: Sections 1311(e)(3)(A) and 2715A require data on the number of claims that are denied to be made available to the public in an accurate and timely manner. However, these have been completely excluded from the list of data elements currently proposed for collection by CMS. This is problematic for consumers shopping for

coverage, as accurate data on claims denials would give them the opportunity to consider how plans have performed comparatively in delivering health care services when choosing a plan. This information is also essential for oversight purposes, as it could reveal discriminatory patterns or patterns of noncompliance with legal requirements based on patterns of denials within certain health plans and the need for oversight to ensure that consumers are being treated fairly and in accordance with relevant federal and state laws.

Recommendation: The guidance should be modified to indicate that data on claims denials will be posted as soon as possible, no later than 2017. Issuers should collect plan-level and de-identified, enrollee-level information on denied claims and make available information about all claims that are submitted but not paid under this category. Issuers should indicate the reason(s) for denials, including medical necessity and other utilization-review determinations, network determinations, application of visit limits, etc. Data on denied claims should reflect service and diagnosis codes. Timelines for claims denials should also be reported. In addition, in 2016, CMS should develop guidance for reporting of appeals of denied claims and on the outcomes of appeals.

Data on Enrollment and Disenrollment: Data on both enrollment and disenrollment at the plan level are critical for ensuring that consumers understand how different plans are serving people. We are very concerned that disenrollment data, required to be displayed under section 2715A and 1311(e)(3)(A), like data on claims denials, are not included in the guidance. It is imperative that disenrollment numbers (and the subsequent reasons behind them) be added to the list of required data elements for collection immediately to help consumers identify a plan that is serving consumers well when shopping for coverage. These data are also important for oversight by regulators and for researchers to spot potential plan problems that may require further investigation.

Recommendation: For both enrollment and disenrollment data, we recommend that CMS rely on plan-level data that we understand issuers are already collecting for premium stabilization (risk-mitigation) programs for this data collection. For the large share of plans that already collect these data, display of these data for 2715A and 1311(e)(3)(A) requirements should begin in 2016 and they should be updated quarterly.

Data on rating practices: In addition to information about rate review, product-level information should be available about tobacco rating so that consumers and regulators can understand how and when tobacco rating is applied in their insurance markets. Health plans that are permitted under law to tobacco rate must already report their tobacco rating factors to regulators, so this information should be collected immediately under sections 2715A and 1311(e)(3)(A).

Information on cost-sharing and payments for out-of-network coverage: We are concerned that the guidance as written does not include information on cost-sharing and payments for out-of-network coverage beyond what is included on issuers' summary of benefits and coverage. Like data on claims denials, information on payments for out-of-network coverage can provide critical insight into whether plans are meeting consumers' needs and complying with federal and state consumer protection standards. Specifically, if a plan has paying a significant number of

out-of-network claims relative to other plans, this may indicate that it does not have an adequate network and is in violation of federal and/or state network adequacy requirements.

Recommendation: In 2016, CMS should provide direction to issuers to modify current claims data reporting to include fields for in- and out-of-network service, to show billed charges in addition to allowed charges, and to indicate the amount of cost sharing applied to each paid claim. For drug claims, modifications should indicate the formulary tier and amount of cost-sharing for each de-identified claim. Modified data reporting should take effect in 2017 and CMS should use this reporting to inform improved network adequacy standards. Oversight efforts should evaluate the overall comprehensiveness of plan provider networks and the relative frequency and cost burden of out-of-network claims on enrollees. It is also important to evaluate plan provider networks more specifically with respect to frequency and cost burden for selected types of services (such as anesthesia and mental health claims) and for selected patient and service/treatment types (such as patients residing in certain geographic areas, or treatments for certain conditions).

Information on enrollee and participant rights under this title:

CMS should use existing data for oversight. In 2016, CMS should begin requiring summary reports, based on currently collected, de-identified claims and enrollment data, and analyze these to assess compliance with ACA nondiscrimination standards. Additional data should be required in future years.

Other information as determined appropriate by the Secretary:

- We support that grace periods and pending claims during the grace period for people who receive premium tax credits will be included in this section. We believe that other grace periods, such as grace periods for employer non-payment of premiums, should be indicated here as well.
- We strongly support requirements to include drug exceptions timeframes and information on how a consumer should read and understand the EOB. This information should be in plain language so that it is easily understandable by all consumers, including those with limited insurance experience.
- CMS should also consider requiring issuers to make available data on in-network balance billing under reference pricing programs in order to identify any developing consumer problems.

Information Uses

Families USA strongly supports the use of the plan data required to be transparent under sections 2715A and 1311(e)(3)(A) for consumers in making informed plan selections and understanding their rights. However, we believe that oversight is equally a priority use for these data, as evidenced by the fact that the Affordable Care Act requires issuers to submit the required data to the Secretary and the State insurance commissioners, and not only to exchanges for public display to facilitate consumer use. Given that regulators often do not have comprehensive data to assess compliance with requirements such as those for network adequacy and non-discrimination, an easy-to-access display of information about plans, including their disenrollment, claims denied, out-of-network payments, and other required figures could provide

essential clues as to whether certain plans are out of compliance with ACA requirements. This important oversight function intended by the ACA should not be neglected.

To this end we are concerned that the guidance indicates that states may consider issuers' submission of data to HHS as fulfillment of the federal requirement to submit information to the state insurance commissioner. We recommend that CMS provides information to state commissioners relevant to their states as it is received so that state commissioners receive the information as CMS does and can use it for oversight purposes, in accordance with the intent of the law.

Recommendation: CMS should immediately implement a systematic review process for of all collected data elements under 2715A and 1311(e)(3)(A) to identify potential patterns of non-compliance or plans otherwise failing to meet consumer needs and to develop measurable standards by which to evaluate plans. CMS should provide state commissioners with the information received by CMS relevant to their state.

We appreciate your consideration of our comments. For further information or should you have any questions, please contact Claire McAndrew, Private Insurance Program Director, at cmcandrew@familiesusa.org or at 202-628-3030.

Sincerely,

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