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

To Whom It May Concern:

The historic rise in health coverage rates underway as a result of the Affordable Care Act makes it more critical than ever for the federal government to promote greater transparency around health insurance companies' performance and practices. Not only can increased transparency assist consumers in making informed decisions about their coverage options, additional data would also help federal and state regulators monitor whether health carriers are delivering on the ACA's promise of strengthened consumer protections. Therefore, we urge CMS to take a far more proactive stance toward the collection of health insurance data than was proposed in the August 12, 2015 Information Collection Notice.

The ACA requirements for increased data reporting by insurers were supposed to take effect in 2010. So the ramp-up to greater transparency must also take into account the fact that consumers have already been waiting five years for new and better information to become available.

Increased transparency, if implemented as envisioned under the ACA, will inform the development of tools and resources that will help people effectively and efficiently navigate the health care system and utilize their health coverage, which will ultimately improve health outcomes. A recent Kaiser Family Foundation poll finds large majorities of the public support efforts to require insurers to publicly report a wide range of data, including data on the availability of in-network doctors and hospitals (84%), how often claims are denied or appealed (83%), how quickly companies pay claims (82%), and what a typical person pays to see a doctor who is not in the plan network (73%). Roughly seven in 10 surveyed said say they would be at least somewhat likely to use each of these types of information when shopping for a health insurance plan.[1] Consumers clearly want and need this information. Further delay in implementation is simply unacceptable.

A. <u>General Recommendations</u>

Accelerate the proposed implementation timeline: We can understand a phased-in approach that provides health carriers in various markets the time they need to begin reporting additional data. However, the proposed timeline would delay indefinitely the meaningful implementation of all transparency data reporting requirements, except for one – the collection of enrollment data for qualified health plans offered through the federally facilitated Marketplace or state-based Marketplace using the federal information technology platform. Even for this element, the single one required in 2016, the proposed approach takes a step backward by requiring plans to report less data than they currently do. CMS should identify specific additional data points that could be collected in 2016 and 2017, at least for some market segments. CMS shouldn't limit data collection only to qualified health plans offered through

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[1] Bianca DiJulio, Jamie Firth, and Mollyann Brodie, "Kaiser Health Tracking Poll," September 30, 2015.

certain Marketplaces. And at least some of the new data should be made public within the next two years.

Immediately begin use of transparency data for oversight purposes: The PRA notice says transparency data would only be used to support consumer decision-making, at least at the outset. Under the law, another key purpose of these data is to support oversight and enforcement. The PRA notice should be revised to outline a plan for use of transparency data reporting for oversight purposes that begins immediately. Oversight involves monitoring and analysis of group health plans and issuers offering coverage in the individual and group markets, in order to better understand evolving norms and their impact on consumers, and to inform development of accountability standards that are enforceable and plan performance rating tools that can help consumers understand and evaluate plan choices.

For example, review and oversight of information about out-of-network claims and patient costs can inform the development of better network-adequacy standards and also inform development of new performance measures to help consumers evaluate the breadth and reliability of health plan networks. Similarly, transparency data also could inform development of plan standards and consumer information tools related to adequacy of health plan drug formularies, discriminatory benefit and cost-sharing designs, and many other important policy issues related to the quality and performance of health coverage that continue to arise. Oversight of transparency could also help identify issues before they negatively impact consumers, by allowing regulators to see when, for example, there is a high disenrollment rate from a particular plan by people with high-cost claims.

Build initial data-reporting requirements around data that issuers already collect: CMS already requires issuers to collect and make available to CMS detailed enrollment and claims data on their ACA-compliant plans in the individual and small-group markets, for purposes of the ACA's risk-mitigation programs. Since 2014, issuers participating in these programs have been collecting comprehensive enrollment and claims data. CMS does not receive or hold the data; issuers store it on their servers, in their external data gathering environments (EDGE servers). CMS runs software on the data, collects reports based on this data, and also requires the data to be verified and audited.

After two years of the ACA risk-mitigation program data collection and reporting, 99.7 percent[2] of issuers using EDGE servers have successfully submitted the data necessary to calculate program payments. Our understanding is that issuers have provided quarterly reports on enrollment and disenrollment data at the plan level. In addition, issuers have been making available detailed data on paid claims, including information on the claimed service, the patient diagnosis, and the plan's allowed amount for each claim (with claims data de-identified to protect enrollee privacy). CMS should build on this data-reporting advancement and begin, in 2016, to require issuers participating in the risk-mitigation programs to begin to make data available for transparency purposes as well. Data storage could continue to be accomplished using EDGE servers. Over the longer term, CMS may also want to consider establishing its own system specifically for transparency purposes.

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[2] "Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year," Centers for Medicare & Medicaid Services, revised September 17, 2015.

The National Association of Insurance Commissioners (NAIC) has also developed a reporting tool to collect data from issuers including detailed information on enrollments, disenrollments, claims (including timeliness of claims payment, in and out-of-network claims, and claim denials), enrollee cost sharing, and grievances and appeals. The NAIC data call has been successfully beta tested in Arizona and Delaware and is now being used as the basis for developing a Market Conduct Annual Statement for Health. At the moment the tool being developed at the NAIC does not collect data at the plan level, but rather at the metal level for each issuer. For purposes of the federal data-transparency requirements, we urge CMS to collect the additional data we recommend for each issuer at the plan level, with "plan" defined as it is in 45 CFR §144.103. Nonetheless, the NAIC tool does include some important details that CMS should adopt, such as the reasons for enrollment terminations.

It is clear that insurance carriers are capable of providing much more information than the PRA contemplates, and CMS should immediately tap into those capabilities in order to improve transparency.

B. <u>Specific Recommended Revisions to the PRA</u>

The Proposed PRA Notice should be substantially revised to require issuers to make available additional data elements in 2016 (at least for ACA-compliant plans in the individual and small-group markets), and to describe for 2017 and beyond a firm timeline for issuers to make additional data elements available and for extending transparency data collection to all non-grandfathered plans, including large-group plans and self-insured group plans. The content of transparency data reporting requirements, covered entities in each year, and the uses for data can be phased in, but this should be done at a pace that results in meaningful enhancements to oversight capability, plan accountability, and consumer information tools as soon as possible.

We urge the following revisions to the PRA Notice required data reporting elements for 2016 and 2017. Unless otherwise noted, all data should be reported at least quarterly. And, unless otherwise noted, all data or performance measures that are made public should be posted on healthcare.gov and displayed with other information about Marketplace plans and non-marketplace plans posted on the plan finder. All data, even if not immediately available to the public, should be shared with state officials for their oversight and transparency efforts.

1. Submission and Display of Data

Any data made public to help consumers learn about their coverage options should ensure that people will be able to find information about a specific plan with as little effort as possible. Consumers using the new tools and data should be able to easily access additional information about a specific plan (such as through a web link) and also be told how to get answers to questions they may have about their specific situation (with display of a phone number to call for in-depth consumer assistance).

To ensure that policymakers will be able to use the new data to evaluate issues such as variation among plans and that organizations will be able to develop tools and resources to improve consumer engagement, any data submitted and/or generated from existing data sources should be provided in a combined format (similar to the Public Use File) and not in separate landscape files by plans as the PRA proposes.

2. Data Elements for Display

a. **Enrollment data**: The proposed PRA notice requires annual reporting of enrollment data at the issuer level, which constitutes a step backward in implementation compared to what is required in the context of the ACA risk-mitigation programs. Under those programs, QHP issuers and issuers offering ACA-compliant individual and small-group market plans outside of the Marketplace (or state exchanges) already report enrollment data to CMS -- at the plan level, and at the de-identified individual enrollee level – on a quarterly basis. Issuers should continue making such data available to CMS in 2016, and CMS should utilize it for transparency purposes. In addition, during 2016, or as soon as practically possible, CMS should post enrollment data for each plan on healthcare.gov. Because issuers currently report enrollment data on a quarterly basis, the enrollment data should be regularly updated to reflect enrollment data from the second prior calendar quarter.

b. **Disenrollment data:** The proposed PRA notice does not mention disenrollment data – a required data element under the statute. Data that issuers make available for the risk-mitigation programs indicate month-by-month changes in enrollment at the plan level and at the de-identified individual enrollee level. In 2016, CMS should require plans to provide summary reports on disenrollment of enrollees based on current data collected on EDGE servers. Disenrollment data reports to CMS should reflect the age and significant medical diagnosis associated with each disenrollment. Later in 2016, CMS should issue detailed guidance on modifications to disenrollment data reporting to capture additional fields that would take effect in 2017. The NAIC data call, for example, separately collects data on disenrollments initiated by the enrollee, disenrollments for premium nonpayment, and disenrollments due to rescission. Initially, CMS would not need to produce plan performance measures on disenrollment for the public. However, in its oversight capacity, the agency should review data for patterns and to identify outliers for further investigation.

c. **Claims payment policies and practices:** The Information Collection Notice proposes that CMS will not collect data about insurers' claims payment practices, but instead merely require insurers to provide a website link where general information about their practices would be provided. This is insufficient. If CMS is going to require this information as an initial effort to improve transparency, it must explain how it is going to verify the information posted by the plans and ensure that it reflects the actual practices of the plans. In addition, this information, if CMS proceeds with its collection, should be made as useful to consumers as possible. To the extent that there are plan- or product-specific differences, this should be clear. Issuers should also be required to include information about specific, relevant features, such as whether any of the issuer’s plans utilize tiered provider networks.

The notice should specify that in 2016 CMS will issue guidance to modify, beginning in 2017, the claims-data reporting requirements for the issuers participating in the ACA risk-mitigation programs. Paid claims information currently collected by issuers on EDGE servers reflects diagnosis and service codes, allowed amounts, and the date of service and payment date for each claim. In 2017, the following elements should also be reported:

- Whether the claim was for in-network or out-of-network services; for plans with tiered networks, the tier should also be indicated
- The amount of cost sharing that was applied to each claim
- The billed charge for each claim
- The date claims were first received by issuers

CMS can also require issuers to submit summary reports of current paid claims data to support oversight. CMS should commence oversight of paid claims data in 2016 using existing data, in order to better understand the timeliness of claims payment, by comparing dates of service to payment dates for claims overall and based on enrollee characteristics (such as age and major diagnosis).

As soon as possible, plan performance measures of claims payment timeliness should be developed for public use. Early on, these data should be utilized for oversight purposes. The NAIC data call collects detailed information on timeliness of claims paid and denied for both in and out-of-network claims. In the beta testing, insurers were able to produce this data.

d. **Data on denied claims**: The proposed PRA notice includes no reporting on denied claims. CMS should revise the final notice to begin accessing data on denied claims 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, as with paid claims, should reflect service and diagnosis codes. Timelines for claims denials should also be reported. Again, the NAIC data call has included reporting on denied claims in and out-of-network.

e. **Periodic financial disclosures**: The proposed notice indicates no new information will be collected from issuers in 2016 under this category. Instead, the notice states that information about issuer premiums and assets, already available on NAIC website, will be sufficient for 2016. This should be revised to require that, in 2016, CMS will develop a new information field for healthcare.gov indicating whether each issuer displayed on the site owed medical-loss ratio rebates in the prior year.

f. **Data on rating practices:** The proposed notice says CMS will rely on the plan-level Unified Rate Review data that is collected annually and displayed on data.healthcare.gov. CMS already requires issuers to submit this information and would not require duplicate submission. However, information about rate review is posted elsewhere on the HHS website and is not readily accessible or understandable for consumers. In 2016 for 2017, CMS should develop the capabilities for healthcare.gov to indicate whether a plan's premium was determined unreasonable and to link to additional rate-review information relevant to that plan on healthcare.gov so that consumers can more easily access this information as part of the plan selection process.

g. **Information on cost-sharing and payments with respect to any out-of-network coverage**: The information about out-of-network cost sharing displayed on the SBC is not sufficient to satisfy this data reporting requirement. Instead, CMS should immediately begin to develop transparent data reporting under this category. As mentioned earlier, 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 it to inform development of 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 claims) and for selected patient and service/treatment types (such as patients residing in certain geographic areas, or treatments for certain conditions.)

h. **Information on enrollee and participant rights under this title**: This is another data-reporting area where agency use of existing data for oversight should precede development of further reporting requirements and plan performance indicators for the public. In 2016, CMS should begin requiring summary reports, based on currently collected, de-identified claims and enrollment data, and analyze these data in light of ACA nondiscrimination standards. Additional data should be required in future years as needed.

   In addition, in 2016, as part of standards developed for reporting data on denied claims, CMS should develop guidance for reporting of appeals of denied claims and on the outcomes of appeals. Again, information on internal and external appeals, including information on whether plan decisions were upheld or overturned at each level, is being collected by the NAIC data call and presumably will be collected under the NAIC MCAS.

i. **Other information as determined appropriate by the Secretary**: This category was included in the law so that full transparency could be achieved and data reporting requirements modified as new plan practices, plan designs, and patient concerns come to light. For example, concerns have been raised about premium payment grace periods and their impact on enrollees, as well as on payment of claims. Accordingly, in 2016, CMS should issue guidance to modify claims reporting data so that pending of claims in this grace period is indicated. Disenrollment data also should be modified to indicate whether the disenrolled individual was in a premium grace period immediately prior to disenrollment. 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. Expanded data requirements should take effect in 2017 for all ACA-compliant plans in the individual and small-group markets.

3. Phasing in Data Collection from Group and "Grandmothered" Plans and Issuers

Under section 2715A of the Public Health Service Act (as added by the ACA), non-grandfathered group health plans and issuers offering coverage in the group and individual markets are subject to the same data-transparency requirements as the issuers of qualified health plans. All of the above recommendations, which we think should immediately apply to ACA-compliant plans in the individual and small-group markets (not just qualified health plans sold through the FFM or using the federal IT system), should eventually extend to all required entities.

We recognize that additional time would be needed to expand data-collection to the full slate of plans and issuers that the transparency requirements apply to. We urge the Administration to establish a clear and proactive timeline for self-insured employer group plans, as well as those in the large-group fully insured market, to meet these expanded reporting requirement. Most people with health coverage continue to be enrolled in employer-sponsored benefits, and they deserve to benefit from the transparency effort as much as those people with Marketplace coverage.

Implementation for large group plans and self-funded plans should begin within a year of implementation for insured small-group plans. Virtually all large-group plans are administered by issuers that also sell fully insured products. As issuers participating in the earlier part of the phase-in become familiar with data-reporting requirements they will be able to transfer this capability to the large-group customers that they insure and/or provide administrative services.

Establishing uniform federal standards for data collection, and building on existing collection requirements, could actually reduce the overall burden on issuers as they work to meet the transparency requirements over time. The NAIC processes will collect information on all insured plans, including large-group plans,

An important near-term step that CMS could take to extend data reporting beyond the universe of issuers and plans that are part of the ACA risk-mitigation programs would be to require basic reporting about so-called grandmothered 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 data in 2016 about the number of such plans and the number of lives they cover.

Sincerely,

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American Cancer Society Cancer Action Network
American Heart Association
American Speech-Language Hearing Association
Autism Speaks
Consumers Union
Enroll America
Epilepsy Foundation
Families USA
Lakeshore Foundation
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