

October 13, 2015

SUBMITTED VIA ELECTRONIC TRANSMISSION

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Attention: **Document Citation 80 FR 48320; Information Collection: Transparency in Coverage Reporting by Qualified Health Plan Issuers, CMS-10572**

Dear Administrator Slavitt:

As organizations that share a strong commitment to the health of our nation's children, we appreciate the opportunity to comment on the recently proposed requirements for transparency in coverage reporting by qualified health plan (QHP) issuers. Nearly one million children are enrolled in QHPs to date, making Marketplace coverage an increasingly important component of children's coverage overall, and helping to bring the rate of uninsured kids to historic lows at just 6.1 percent in 2014. Overall, more than half of children are covered by private health insurance plans that would be impacted by these transparency requirements.

As the Affordable Care Act has been successful in its efforts to expand coverage to millions of Americans, the attention of policymakers, advocates, and families will increasingly turn to the value of this coverage and the nature of the choices available to those looking for coverage in the marketplace. This is especially true for families of children with serious, chronic or complex health conditions. Therefore, while we applaud you for starting the process to require health plans to collect health insurance data as proposed in the August 12, 2015 Information Collection Notice, we believe that a more comprehensive approach is needed to ensure that the data informs both policy and consumer choice.

First, we would like to respectfully remind CMS that the Children's Health Insurance Program (CHIP) – a long-standing and successful source of coverage for children – is currently funded only through 2017. More information is needed during this relatively short window before lawmakers will have to once again choose whether to extend funding for CHIP. In that regard, it is critically important that policymakers also have robust information to better understand whether and how low and moderate-income children are being served by QHPs.

For example, a study by the Georgetown University Center for Children and Families examined specific scenarios to show that families most often face higher out-of-pocket costs in QHPs compared with CHIP.¹ However, not enough is known about the experience of children with marketplace coverage – including benefits, cost sharing, provider networks, and quality of care.

¹ T. Brooks, M. Heberlein, & J. Fu, "Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs," Georgetown University Center for Children and Families and Children's Action Alliance (May 2014), available at: <http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf>.

Without comprehensive, accurate, and timely data about the experience that children have under this coverage, it is difficult to answer the policy questions raised by the potential end of CHIP in 2017.

In addition, we strongly believe that it is important to understand the full range of coverage options available to children throughout the market to ensure they are able to get the full range of services they need to grow and thrive. Data from these plans not only will assist families in choosing an appropriate plan but can help drive future policy in key areas for pediatric health care such as enrollment, benefits, provider networks and cost sharing. Therefore, though the proposal focuses on data reporting requirements for QHPs sold through the Federally-facilitated Marketplaces (FFMs) and those state-based Marketplaces (SBMs) that use the federal information technology platform, similar data collection requirements should be applied throughout the market as soon as possible.

Below, we address ways to improve the proposed requirements that would better inform families and other stakeholders on the nature of coverage available through the marketplace, as well as inform policy choices about the future of children's coverage.

Implementation timeline

Given that insurers and employers were supposed to start reporting back in 2010, there is little reason to delay many of the data reporting requirements indefinitely, as the current proposal does. We urge CMS to adopt a specific timeline for required reporting of all required data elements for Marketplace and non-Marketplace plans so that insurers and other stakeholders can adequately plan for and expect specific data in the future. Again, such information is needed to inform not only the choices that consumers make, but also the actions of policymakers evaluating quality of the various sources of coverage available to children.

Data reporting requirements

Enrollment data: We are concerned about the proposal to only require the reporting of issuer-level enrollment numbers. For many families, the choice of a particular plan among many plan options is likely a more consequential decision than deciding between insurers. The proposed requirements acknowledge this by stating that, "CMS expects consumers to access this information to make informed plan selections and understand their rights as consumers." Disaggregated, plan-level enrollment data that includes information on enrollee income, geographic location (state), and demographic information (race/ethnicity/income/age) would allow policy makers, regulators and stakeholders to document, identify, and analyze patterns in consumer behavior and in coverage, such as consumer movement between plans and different coverage levels. Further, such data would be much more useful to families surveying the options available to them. This plan-level data would help show how different factors interact, helping stakeholders to understand how changes in a plan's network or premium affect consumer choices and to identify possible gaps in coverage options. Since insurers selling QHPs already report plan-level enrollment data to CMS with de-identified enrollee information, this level of data should not pose an additional burden on carriers.

Disenrollment data: Though the proposed requirements do not call for disenrollment data, plan-level disenrollment data would also help shed light on how consumers are experiencing different plans. While year-by-year plan-level enrollment data would illustrate consumer behavior with regard to initial plan selection, disenrollment data would add depth to our understanding of which plans consumers are leaving and why.

Claims data: Claims data can provide important insights into the quality of coverage throughout the market. To get a better picture of children’s coverage, issuers should report the following paid and unpaid claims data by age and income, with diagnosis and service codes:

- Whether the claim was for in-network or out-of-network services; for plans with tiered networks, the tier should be indicated;
- The amount of cost sharing that was applied to each paid claim;
- The billed charge for each claim;
- The date claims were first received by issuer; and
- For unpaid claims, information about the reasons for denials should be reported, such as medical necessity and other utilization review determinations, provider network limits, application of visit limits, etc.

In addition, issuers should provide claims data that indicates how cost-sharing rules are applied for in-network care versus out-of-network. For example, data should include the extent to which, if at all, the out-of-network expenses apply towards the consumer’s maximum out-of-pocket costs or the deductible.

Aggregating, summarizing, and displaying reported data

The way in which the reported data is presented is almost as important as having the data itself, especially for families that have to navigate a great amount of information in assessing their options and making informed choices. Therefore, CMS should ensure that this data is presented and summarized in a way that is understandable for consumers. For example, the proposed requirements state that issuers can “link to existing documents that provide this information, such as plan documents...Alternatively, issuers could fulfill this requirement by providing a few sentences or a short paragraph explaining each topic.” Consumers will benefit most if they have access to the actual documents and summary that is either approved or provided by CMS. Furthermore, all health plans should be required to create plan documents and summaries that are in a uniform format. As you know, the Summary of Benefits and Coverage, as required under the Notice of Benefits and Payment Parameters for 2016 provides a model for a uniform format of summary information. We recommend that CMS adapt a similar format for summary data displays, but also develop a uniform format of the full display of plan data. Consumers should easily be able to get information about a specific plan and learn where they can get more information. In addition, CMS should also develop features such as sorting tools that allow consumers to organize the data in different ways.

Finally, the proposed requirements indicate that, for initial implementation, each QHP issuer’s information will display separately in a landscape file, though CMS will move to a “more dynamic format in future years.” To assist consumers, other stakeholders and oversight officials, this information should be compiled and provided collectively in an easy to download format (as CMS already does through the Public Use File).

Policymakers should use reported data for continuous oversight

The proposed requirements state that, “CMS does not intend to use the information submitted in this PRA package for oversight purposes.” This is perplexing. There is no doubt that the rationale behind the Affordable Care Act’s reporting requirements was for both the public and policymakers

to gain insight into how insurance is working for consumers based on how their plans are designed and administered. The agency should review all reported data for patterns, including short and long-term trends, that warrant further investigation and possible policy changes. For example, the availability of such data could help determine if children with serious, chronic or complex health conditions, such as children with a congenital heart defect or cystic fibrosis, are enrolled disproportionately in particular kinds of plans, indicating uneven risk selection among plans. In addition, robust claims data could identify a pattern of coverage denials for certain types of high-cost services by specialty providers that may indicate discriminatory benefit or plan design. To help ensure that plans are providing children and families with access to high quality and timely care promised to them in their plan contract, it is critical that CMS use plan data to inform effective oversight and policymaking.

Finally, the PRA provides no indication of how CMS plans to enforce the data reporting and transparency requirements. We urge CMS to delineate the specific enforcement mechanisms it will implement including consequences and penalties that might be imposed should issuers not comply with these important reporting and transparency requirements.

Sincerely,

Children's Dental Health Project
Children's Hospital Association
First Focus
Georgetown University Center for Children and Families
March of Dimes
National Association of Pediatric Nurse Practitioners

cc: Kevin Counihan, CCIIO Deputy Administrator and Director
Vikki Wachino, CMCS Deputy Administrator and Director