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October 13, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-10572
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via: http://www.regulations.gov

RE: Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS-10572) – AHIP Comments

Dear Mr. Slavitt:

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Information Request related to transparency in coverage reporting by qualified health plan (QHP) issuers, published in the *Federal Register* on (80 FR 48320) on August 12, 2015, and the subsequent detailed information posted on the CMS Paperwork Reduction Act (PRA) website. AHIP is the national association representing health insurance plans that provide coverage to more than 200 million Americans.

We support a phased in and measured approach to meet the transparency requirements required by section 1311(e)(3) of the Affordable Care Act (ACA). Our recommendations focus on how to provide information that would be meaningful to consumers in a way that leverages existing data sources. We agree that consumers must have access to a wide-range of information to support their decision making process for Exchange coverage, however many of the data elements included in the ACA and subsequent exchange regulations at 45 CFR 156.220(a) would be of little interest to consumers. As we indicated in past Agency comments, several data elements included in the regulations are no longer relevant (i.e., rating practices), contain information that would be considered competitively sensitive or not provide information to differentiate QHPs in

a meaningful way (i.e., enrollment and disenrollment) or are subject to thorough review by state regulators (i.e., periodic financial disclosures). [1,2]

We support the collection of data elements proposed by CMS, consisting of an issuer URL containing a description of claims payments and practices and other basic contact information. We encourage CMS to finalize this data collection as proposed, however we are concerned about the potential display of several data elements on healthcare.gov (issuer enrollment and rating practices) that will be pulled from existing CMS data sources.

QHP Issuer Data Collection – Appendix A

We strongly support the proposed phased approach for the collection and display of transparency information. This approach makes the most sense –starting with and learning from experience of QHP issuers in the FFM and SBMs using the Federal platform, and in the future addressing both QHP issuers in SBMs, and non-grandfathered group health plans and issuers offering individual coverage (non-QHP issuers). While our comments are specific to the proposed data collection and display for this first phase, they are also geared at informing future phases.

We agree with the approach proposed by CMS whereby issuers may leverage existing consumer-facing resources to meet transparency reporting requirements. Appendix A outlines the data elements to be collected from QHP issuers for the first phase of transparency in coverage reporting. In addition to basic plan and contact information, CMS proposes to require that issuers submit URLs to a landing page on the issuer's website that will direct consumers to information on various topics related to claims payment and policies, such as pending claims and grace periods, submitting claims and balance billing, prior authorization, coordination of benefits, etc. To meet this requirement, issuers may use existing consumer-facing resources for this data collection, including links to existing websites, Summaries of Benefits and Coverage (SBCs) or other plan documents, or include a short description. Using existing website content will also ensure that consumers receive consistent information and reinforce the importance of referring to existing plan resources like plan documents and SBCs.

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[1] Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2016 – America's Health Insurance Plans Comment Letter. http://www.regulations.gov/#!documentDetail;D=CMS-2014-0152-0218. December 22, 2014.

[2] Section 1311(e)(3) of the Affordable Care Act and 45 CFR 156.220(a) include data on: (1) claims payment policies and practices; (2) periodic financial disclosures; (3) enrollment; (4) disenrollment; (5) the number of claims that are denied; (6) rating practices; (7) information on cost-sharing and payments with respect to any out-of-network coverage; and (8) information on enrollee rights under ACA Title I.

CMS should clarify the level at which the URL should be provided. We recommend that the URL is specific to the issuer – as much of this information would be consistent across the issuer level and this would allow for plans to discuss any state specific variations.

QHP Issuer Data Display – Appendix B

In Appendix B, CMS describes data elements that would be displayed to consumers. CMS proposes to display the URL links to information related to claims payment policies and practices collected from issuers, as well as the following data from existing sources:

- Link to an NAIC web page listing information related to periodic financial disclosures;
- CMS data on issuer-level data on enrollment in the FFM;
- Data on rating practices via the Unified Rate Review Template (URRT) on data.healthcare.gov;
- Information on cost-sharing and payments for out-of-network coverage via the SBC on healthcare.gov; and
- Link URL to the enrollee rights under Title I and protections of information provided on healthcare.gov.

We support the proposed use of existing data sources for information on periodic financial disclosures, rating practice data, information on out-of-network coverage and general information on Title I, which is consistent with our recommendations related to transparency in our 2016 Notice of Benefit and Payment Parameters comment letter. We support the collection and display data from existing resources rather than creating a new data collection, especially for information that has already been reviewed and collected by the state. However, we recommend CMS releases additional information on the exact data elements to be displayed to consumers.

We have concerns about the proposal that CMS will display issuer enrollment data and raise some timing concerns about the URRT data:

- *Issuer Enrollment Data:* Marketplaces should encourage consumers to look at critical components of coverage, including provider networks, benefits, formulary drug coverage, and total cost of coverage, to determine which plan will best serve their specific needs rather than enrollment. Plan selection is a very person-unique experience and comparing enrollment numbers across issuers should not be an element by which consumers compare plans. If CMS does display this information, we recommend enrollment be displayed at the issuer level due to the competitively sensitive nature of this information.

- *Rating Practices:* CMS proposes to display data on rating practices via the URRT, which is the template that QHP issuers are required to submit. We support CMS' current

practice to not release detailed benefit or rate information until after the finalization of the QHP certification. We recommend that CMS continue that practice and not publish rating information from the URRT for purposes of transparency reporting until after QHP certification is complete. If CMS were to release rating information from the URRT before the QHP certification process closed, other issuers could gain a competitive advantage and change their rates accordingly.

Thus, CMS should clarify that when it accesses rate information from the URRT or "other data sources" for transparency in coverage requirements that rates are final and approved and QHP agreements have been signed before being released in a public use file for purposes of transparency reporting. CMS should also develop a process to ensure no proprietary or confidential information from the URRT or elsewhere is displayed and ensures that transparency reporting does not disrupt the insurance market through the premature release of rating and enrollment information when such information could be competitively sensitive.

We recommend rating data is displayed at the issuer level as opposed to at the product or plan level.

Finally, with respect to how data will be displayed to consumers, we support CMS' proposal to display each issuer's information in separate landscape files available on data.healthcare.gov. CMS already successfully posts publicly available data there, such as the individual and SHOP landscape files, and stakeholders and researchers are familiar with the site and file format. We recommend that CMS publish a sample display/layout for this landscape file with details on how issuer information and information from other sources will be displayed to consumers. We look forward to the opportunity to provide feedback on any future changes to the display of transparency information in future years.

Timing and Method for Data Submission

We support the use of a separate reporting process (e.g., via email) for the initial transparency data collection and also agree that it would make sense to align this reporting with the QHP certification process in future years.

We expect that CMS will release public use files with transparency information consistent with other public use files released immediately prior to each open enrollment period. Thus, CMS should provide ample time collect and validate transparency data before this information is released. We recommend CMS provide the final data elements and format at least 6 months in advance of the submission deadline. As stated above, because some of the data is competitively sensitive, transparency landscape files should not be released until the end of QHP certification when countersigned agreements are returned to issuers. Some information that CMS proposes in

Appendix B, such as SBCs, are not available until QHPs have been approved. It could also potentially be confusing to consumers to release the transparency landscape files prior to open enrollment, or the time when QHP landscape files are released, whichever is earlier, because the transparency data otherwise would not align with QHPs available on the Marketplace. In addition, as is the current standard for other URLs collected during the QHP application process, transparency-related URLs should not be required to be active and directly route the user to the appropriate document until the issuer has signed its QHP agreements.

Other ACA Required Data Elements

While not all ACA-required transparency data elements are included in this data collection, we agree with the approach that CMS proposes for implementing this requirement. We support CMS in not including certain data elements in this initial data collection because they are not relevant consumers in the plan selection process. Specifically, data on disenrollment or the number of denied claims could be misleading if taken into account as part of the plan selection process. Consumers should be encouraged to examine plan attributes that will contribute to the affordability of coverage, quality of coverage, and whether that coverage meets their needs. Thus, we support CMS in not finalizing requirements for these data elements in this phase of transparency in coverage reporting and recommend they not be required for any future iteration of transparency data collection. Consistent with our previous recommendations, we provide the following detailed feedback:

- Data on disenrollment. Data on disenrollments could be misleading if used by consumers in making plan selection decisions. The Marketplace should encourage consumers to look at critical components of coverage, including provider networks, benefits, formulary drug coverage, and total cost of coverage, to determine which plan will best serve their specific needs rather than enrollment and disenrollment data. High disenrollment indicators do not provide insight into the value of coverage for an individual's or a family's specific needs. Consumers disenroll from coverage for a variety of reasons, including gaining other minimum essential coverage, a change in life circumstances, change in eligibility, and an enrollee's ability to make monthly premium payments. These factors are not reflected in disenrollment data.

  If CMS was to make this information available in the future, we recommend that studies be conducted with consumer response to this information to better understand potential unintended consequences. In addition, if displayed on healthcare.gov, it should not be presented in a way that could lead consumers to draw inappropriate conclusions from it.

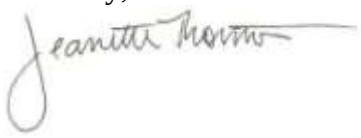
- Data on the number of claims that are denied. We are concerned that displaying data on denied claims would present misleading information to consumers. Claims are denied for many reasons that are not within the control of the QHP issuers and developing a

definition of what constitutes a claim and a claim denial would be quite complex. Some of the most common reasons for claims denials include insurance eligibility, duplicate claims, insufficient information provided to process the claim, and denials due to inaccurate claims coding. Surveys have shown that nearly half of all claims were pended due to the submission of duplicate claims, lack of complete information or other information needed to justify the claim, or invalid codes. Twenty four percent of pended claims were due to coverage issues, including no coverage based on date of service, non-covered or non-network benefit or service, coordination of benefits or due to a request for a review of the medical records. A May 2011 GAO Report, *Private Health Insurance: Data on Application and Coverage Denials*, also confirmed that many claim denials, some administrative in nature, are ultimately paid. A definition of claims denial must factor in these situations so consumers are not presented with misleading information about the QHP issuer. Where possible, the definition of denied claims should be consistent with existing definitions or measures.

Because of the complexity of developing a definition for denied claim and potential for this information to be confusing or misleading for consumers, we recommend that it not be included in future iterations of reporting.

Thank you for the opportunity to provide comments. Please do not hesitate to contact me if you have any questions at 202-861-1491 or jthornton@ahip.org.

Sincerely,



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