NATIONAL WOMEN'S LAW CENTER
EXPANDING THE POSSIBILITIES

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

Date: October 13, 2015

The National Women's Law Center (the Center) strongly supports the Administration's efforts to implement the Affordable Care Act (ACA) and make quality, affordable health insurance available to millions. We appreciate the opportunity to provide these comments to the Department of Health and Human Services on the Paper Work Reduction Act Notice on Information Collection for Transparency in Coverage Reporting by Qualified Health Plan Issuers (PRA).

Since 1972, the National Women's Law Center has worked to protect and advance the progress of women and their families in core aspects of their lives, with an emphasis on the needs of low-income women. The National Women's Law Center has long advocated for women's health care and reproductive rights. The Center's comments on the PRA reflect extensive research on coverage of women's specific health needs in state Marketplaces in 2014 and 2015, reports from the Center's hotline for women's preventive services, *CoverHer*, and the Center's expertise on women's health.

CMS should take a far more proactive stance toward the collection of health insurance data than was proposed in the August 12, 2015 Information Collection Notice. Given that the ACA requirements for increased data reporting by insurers were supposed to take effect in 2010, CMS should accelerate and broaden its proposed approach.

A. General Recommendations

Accelerate the proposed implementation timeline: The proposed timeline would delay indefinitely the meaningful implementation of all transparency data reporting requirements other than the collection of enrollment data for certain qualified health plans – that is, those offered through the federally facilitated Marketplace or state-based Marketplace using the federal information technology platform. Even for this element, the proposed approach takes a step backward by requiring plans to report less data than they currently report. This is not acceptable. CMS must identify specific additional data points that plans must collect in 2016 and 2017, for some market segments. At least some of the new data should be made public within the next two years.

Expand the scope of the implementation: CMS must not limit data collection only to qualified health plans offered through certain Marketplaces. The statute specifically

applies the transparency in coverage requirements to group health plans in Sections 1311(e)(3)(D) of the ACA.[i] Extending the requirements to group health plans will help the Administration address ACA violations. The Center's recent reports on issuer compliance with the ACA include examples from our nationwide consumer assistance hotline, which demonstrate that many employment based health plans are not in full compliance with the law's requirements related to women's health –specifically with the preventive services requirements for birth control coverage and breastfeeding support and supplies.[ii]

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. CMS should revise the PRA notice to outline a plan for immediate use of transparency data reporting for oversight purposes. 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, to inform development of enforceable accountability standards that are enforceable and to hone plan performance rating tools that can help consumers understand and evaluate plan choices.

Today, too many plans offer coverage that does not comply with the ACA. The Center's recent analysis of 2014 and 2015 QHPs offered in 15 states found numerous violations of the ACA that appropriate reporting requirements could have flagged for the states and CMS:[iii] To summarize the Center's "State of Coverage" reports:

- Fourteen issuers across seven states offered maternity coverage that does not comply with the ACA, such as excluding maternity care coverage for dependents.
- Fifty-six issuers across thirteen states offered coverage of preventive services that does not comply with the ACA, from imposing impermissible limits on coverage of breastfeeding supports and supplies, to not covering well-woman visits as required, to offering coverage of genetic testing that does not comply with the law, to failing to offer birth control coverage as required by law.
- One issuer in one state impermissibly limited coverage of abortion.
- Seven issuers in four states impermissibly limited essential health benefits in ways that restrict women's access to critical services, such as improperly limiting drug coverage and maintenance therapies or establishing waiting periods for certain services.
- Ninety-six issuers across twelve states offered coverage that does not comply with non-discrimination provisions of the ACA, such as violating prohibitions on sex discrimination, restricting coverage based on age, excluding care for transgender people, or excluding coverage of chronic pain treatment.

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.

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.

Phasing in Data Collection from Group and Hold-Over 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. Through the *CoverHer* hotline, the Center has heard from women with group health insurance in every state who have experienced problems accessing preventive care. Data transparency for these plans would enable regulators to identify these problems (and other problems with these plans) more efficiently.

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 expanded reporting requirements. Most people with health coverage continue to be enrolled in employer-sponsored benefits, and they deserve to benefit from this 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.

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 from hold-over plans – those that have continued to cover individuals and groups for a limited period of time without complying 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.

B. Key Revisions to the PRA for Oversight and Enforcement

Based on the "State of Coverage" reports and information reported to the *CoverHer* hotline, state and federal officials need to significantly improve oversight and enforcement to ensure that women receive the health services guaranteed by the ACA – and improved plan reporting will further these efforts. We therefore urge the following revisions to the required data reporting elements for 2016 and 2017. Unless otherwise noted, plans should report all data 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.

To ensure that policymakers will be able to use the new data to evaluate issues such as variation among plans, 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. We also 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.

1. 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. Issuers should continue making plan-level, and de-identified individual enrollee level data available to CMS in 2016. 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.

2. Disenrollment data: The proposed PRA notice does not mention disenrollment data – a required data element under the statute.[iv] 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. 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. 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.

3. Claims payment policies and practices: Based on the Information Collection Notice, CMS will not collect data about insurers' claims payment practices, but instead merely require insurers to provide a website link with general information about their practices. This is insufficient. Our reports show the significant compliance problems related to required benefits. Claims reporting can help CMS determine whether plans are providing coverage as required under the ACA and to identify problematic trends. For example, a very small percentage of women with maternity claims filing claims for breastfeeding support or supplies might indicate a problem with women's access to this benefit. Similarly, a combination of few or no in-network claims for lactation counseling and support and a large number of out-of-network claims that are denied or partially reimbursed for this service might be a sign that does not have an adequate network of lactation consultants and that the plan is not appropriately covering the services out of network. In addition, information on payment policies and practices should be made as useful to consumers as possible. Any plan- or product-specific differences should be clearly apparent. CMS should also require issuers 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, claims-data reporting requirements for issuers participating in the ACA risk-mitigation programs. Paid claims information currently reflects diagnosis and service codes, allowed amounts, and the date of service and payment date for each claim. In 2017, CMS should require issuers to report the following elements:

- 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).

4. Data on denied claims: The proposed PRA notice includes no reporting requirement for denied claims. Denied claim information could provide CMS with importance compliance information, such as if a plan is denying claims for birth control, well-woman visits or other preventive services. 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, and application of visit limits. Data on denied claims, as with paid claims, should reflect service and diagnosis codes. Timelines for claims denials should also be reported.

5. 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.

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. In that year, CMS should review data reports to inform development of improved network adequacy standards for the FFM. This data can also help CMS determine whether plans are covering preventive services without cost sharing, as required, when they do not have an adequate network. 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, treatments for certain conditions).

C. Additional Recommendations

The revised PRA should also include the following changes. While not connected to the "State of Coverage" findings and hotline reports, these items are important to all consumers, including women.

1. Periodic financial disclosures: CMS should 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.

2. Data on rating practices: CMS should develop the capabilities for healthcare.gov to indicate, in 2017, 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.

3. 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.

4. Other information as determined appropriate by the Secretary: This category was included in the law to promote full transparency and to ensure that CMS can modify data reporting requirements as new plan practices, plan designs, and patient concerns come to light. Current concerns include 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. In addition, disenrollment data should 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.

Thank you for the opportunity to comment on these important issues.

Sincerely,

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[i] 42 U.S.C. § 13031(e)(3)(D).

[ii] See Nat'l Women's Law Ctr, "State of Birth Control Coverage: Health Plan Violations of the Affordable Care Act," (April 2015) available at http://www.nwlc.org/sites/default/files/pdfs/stateofbirthcontrol2015final.pdf; Nat'l Women's Law Ctr, "State of Breastfeeding Coverage: Health Plan Violations of the Affordable Care Act," (May 2015) available at: http://www.nwlc.org/sites/default/files/pdfs/final_nwlc_breastfeedingreport2015.pdf.

[iii] Nat'l Women's Law Ctr, "State of Women's Coverage: Health Plan Violations of the Affordable Care Act," (April 2015) available at: http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf.

[iv] 42 U.S.C. § 13031(e)(3)(A).