America's Health Insurance Plans
601 Pennsylvania Avenue, NW
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December 21, 2018

Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: OMB Control Number 0938-1310
Room C4–26–05
7500 Security Boulevard
Baltimore, Maryland 21244–1850

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

RE: Document Identifier: CMS–10572—Transparency in Coverage Reporting by Qualified Health Plan Issuers–AHIP Comments

Dear Sir or Madam:

On behalf of America's Health Insurance Plans (AHIP), I am writing to provide comments in response to the Information Collection request for comment related to Transparency in Coverage Reporting by Qualified Health Plan (QHP) Issuers, published in the *Federal Register* on October 23, 2018, and the related Paperwork Reduction Act (PRA) Notice.

AHIP is the national trade association representing the health insurance community. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We support CMS' efforts to ensure consumers have access to important information about their options when shopping for health insurance coverage. Information made available to consumers should be conveyed in a manner that is easy to understand and actionable. Reporting requirements for health insurance providers should be reasonable and only require the minimum necessary data to avoid creating unnecessary administrative costs.

In our prior comments related to QHP transparency reporting requirements, we discussed the challenges inherent in reporting and displaying complex information like claim denials in a manner that is meaningful to consumers. We recommended CMS delay claims denial reporting requirements until the NAIC completed work to establish definitions of a claim and denial categorizations through the Health Market Conduct Annual Statement (MCAS). The Health MCAS is a reporting tool used to provide states with certain data otherwise not available for purposes of market conduct review. It was adopted in August 2016 and issuers reported data for the first time on September 20, 2018 for 2017 plan year data. The next reporting deadline is May

31, 2019 for 2018 data. Not all states participate, meaning not all QHP issuers are subject to MCAS reporting requirements. Because MCAS and QHP transparency reporting requirements include claims, denials, and appeals, discrepancies in definitions, categories, and reporting timeframes has the potential to create duplicative requirements for those issuers that must report to both.

We appreciate CMS is now working to leverage the NAIC's MCAS definitions to align issuer reporting requirements. However, we are concerned the proposed modifications to claims denial classifications for QHP transparency reporting would still result in duplicative reporting requirements for issuers who must report to MCAS and would not reduce administrative burden.

Unless the data elements and submission timelines are perfectly aligned, issuers will continue to be subject to duplicative data submissions. NAIC is still refining the MCAS data elements and definitions, making it a moving target and difficult to align the QHP transparency requirements. Even minor discrepancies in data definitions, guidance, and submission deadlines would require issuers to make system changes to support the two different sets of requirements. This would not achieve the goal of reducing administrative burden, set forth by the Administration in Executive Order 13765, which directs HHS to minimize regulatory burdens of the Affordable Care Act.

As proposed, there are differences between the MCAS and QHP transparency definitions and categories for claims denials. For example, QHP transparency data is reported at the plan level while MCAS is reported at the metal level and QHP transparency data is reported by the date received, serviced, and denied while MCAS is reported by the date received, paid, and denied. Further, the difference in submission deadlines for the QHP transparency and MCAS data collections would require issuers to do two separate data pulls and would result in discrepancies. In effect, issuers would still be required to make systems changes to support separate reporting requirements for QHP transparency and MCAS. For issuers subject to both reporting requirements, the operations burden could be significant.

To reduce administrative burden and avoid unnecessary duplicate data collections, we recommend CMS maintain the current definition and reporting requirements for denials and not finalize the proposed changes. Specifically, we recommend:

- **CMS should not adopt the proposed changes to collect plan-level claims denials or use new denial classifications at this time.** The NAIC is expected to continue its work to streamline and clarify the 2018 MCAS filing materials, including data definitions. Once the NAIC has finalized this work, we support re-considering aligning the QHP transparency reporting requirements related to claims, denials, and appeals with MCAS. This approach would avoid iterative changes to the QHP transparency requirements to stay in sync with the evolving MCAS data elements and definitions, thus reducing the administrative burden of multiple revisions. In the meantime, CMS should continue to

collect issuer-level claims denial information using the existing definition and categorization.

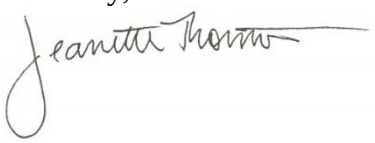
- **CMS should not add a new data element to collect information on "overturned claims denied."** Issuers have not been required to report "overturned claims denied" in the past and it is not clear what is meant by this data element. It is not clear how this data element would be distinguished from or overlap with the existing appeals reporting requirement. We recommend CMS not add this new element to the issuer-level claims data collected.

- **CMS should ensure a consistent definition of a "claim" throughout the transparency reporting instructions.** The 2018 plan year QHP transparency instructions state "a claim means any individual line of service within a bill for services (medical and pharmacy, including pharmacy point of sale)."[1] To ensure consistency, we recommend CMS clarify this "line level" definition of a claim throughout the instructions.

Maintaining consistency in the QHP transparency reporting requirements would provide stability and avoid creating new costs to comply with regulatory requirements. If CMS attempts to align QHP transparency requirements with MCAS now, additional changes would be needed in the future after NAIC additional updates to refine the MCAS reporting model. These iterative changes would increase the burden and costs for issuers to comply with this reporting requirement. Consequently, we recommend CMS wait for NAIC to finalize revisions of MCAS data elements and definitions to ensure that is a stable process before aligning the QHP transparency requirements.

Maintaining the current QHP transparency data collection while waiting for MCAS to be finalized before attempting to align the claim, appeal, and denial reporting requirements would mitigate the administrative costs of iterative updates while working toward the goal of alignment in transparency reporting. Thank you for the opportunity to provide comments on this proposed data collection. If you have any questions, please contact Kelley Turek at kturek@ahip.org or 202-861-1459.

Sincerely,



Jeanette Thornton
Senior Vice President, Product, Employer and Commercial Policy

[1] Instructions for Submission of QHP Transparency in Coverage Data for Plan Year 2018. May 24, 2018.