SUPPORTING STATEMENT-PART A

Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS-10572)

A. Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (P.L. 111-148). On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 (P.L.111-152) was signed into law. The two laws are collectively referred to as the Affordable Care Act. The Affordable Care Act established new competitive private health insurance markets called Marketplaces, or Exchanges, which give millions of Americans and small businesses access to affordable, quality insurance options. By providing a place for one-stop shopping, Marketplaces make purchasing health insurance easier and more transparent, and put greater control and more choice in the hands of individuals and small businesses. The law also established changes to the market in general, including individual, small group, large group, and self-insured plans.

Sections 1311(e)(3)(A)-(C) of the Affordable Care Act as implemented at 45 CFR 155.1040(a)-(c) and 156.220, establish new standards for qualified health plan (QHP) issuers to submit specific information related to transparency in coverage. QHPs are required to post and make data related to transparency in coverage available to the public in plain language and submit this data to the Department of Health and Human Services (HHS), the Marketplace, and the state insurance commissioner.

These new standards will lead to greater transparency for consumers and assist in the decision-making process. The Centers for Medicare & Medicaid Services (CMS) is creating a new information collection request (ICR) in connection with these standards. The burden estimate for this new ICR included in this package reflects the time and effort for certain QHP issuers to submit the appropriate data to CMS.

Section 2715A of the Public Health Service Act (PHS Act) as added by the Affordable Care Act largely extends the transparency provisions set forth in section 1311(e)(3) to non-grandfathered group health plans and health insurance issuers offering group and individual health insurance coverage.[1]

[1] The implementation of the transparency reporting requirements under section 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under section 2715A of the PHS Act, incorporated into section 715(a)(1) of the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (Code) and will be the subject of a separate, future rulemaking. See FAQs About Affordable Care Act Implementation (Part XXVIII), available at http://www.dol.gov/ebsa/faqs/faq-aca28.html and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Part-XXVIII-transparency-reporting-final-8-11-15.pdf.

B. Justification

1. Need and Legal Basis

I. Regulatory Background

Pursuant to 45 CFR 156.220, in order to increase transparency of QHPs on the individual Marketplace and Small Business Health Options (SHOP) Marketplace, including Stand-alone Dental Plans (SADPs), issuers must submit specific information about coverage to HHS, the Marketplace, and the state insurance commissioner, and make the information available to the public in plain language. Section 156.220(b) requires issuers to submit the information outlined in §156.220(a) in an accurate and timely manner to HHS, the Marketplace, and the state insurance commissioner and to make it available to the public. Section 156.220(c) requires issuers to make this information available in plain language as defined under 45 CFR 155.20.

As stated in the preamble to the rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule* (80 Federal Register 10750, 10829-10830, February 27, 2015), collection and public display of this information from QHP issuers offering coverage through Marketplaces will begin in 2016. We intend to make some collection and display optional in 2016, as detailed below. Beginning in time for open enrollment in 2017 (for coverage in 2018), collection and public display of all data elements will be required.

II. Phased-in Approach

A. Phased-in Approach for QHP Issuers

Based on the comments we received to the 60-day comment period, we are maintaining a phased-in approach, as initially proposed. We are also adding more data collection points for collection and display that will occur in 2017 and 2018, which are detailed further below. Based on comments received to the 30-day comment period and initial implementation, we will consider adding additional data elements for 2018. This proposed collection sets forth the first phase of implementing the transparency requirements established under section 1311(e)(3) of the Affordable Care Act.

CMS intends to first require QHP issuers in the Federally-facilitated Marketplaces (FFMs), those state-based Marketplaces (SBMs) and state-based Marketplaces on the Federal Platform (SBM-FPs) that use the federal information technology (IT) platform, more commonly known as HealthCare.gov, to report on transparency. These transparency requirements will be phased in for other QHP issuers in a subsequent ICR.

Issuers offering QHPs in SBMs that do not use the federal IT platform will not be found to be out of compliance with 45 CFR 155.1040(a) prior to the promulgation of requirements for such SBMs in a subsequent ICR.

A future ICR may also include modification to existing data elements and additional data

elements as authorized under 1311(e)(3)(A)(iv) and (v) of the Affordable Care Act, as well as other information that CMS may deem appropriate. For example, in the future, CMS may propose collecting certain elements at the product or plan level instead of the issuer level and may propose collecting more granular data on claims denials and disenrollment. Additionally, CMS is following the National Association of Insurance Commissioners' (NAIC) work towards finalizing the Market Conduct Annual Statement (MCAS), which proposes to collect similar data categories. CMS will endeavor to align any future packages with the final MCAS.

B. Future Transparency Reporting Rulemaking for Non-QHP Coverage

Consistent with the requirements of PHS Act section 2715A, HHS, the Department of Labor, and the Department of the Treasury (collectively, the Departments) intend to propose transparency reporting requirements, through separate rulemaking, for health insurance issuers offering group and individual health insurance coverage (non-QHP issuers) and non-grandfathered group health plans (including large group and self-insured health plans). The proposed reporting requirements may differ from those prescribed in the HHS proposal under section 1311(e)(3) of the Affordable Care Act, will take into account differences in markets, and other relevant factors, and importantly, the Departments intend to streamline reporting under multiple reporting provisions and reduce unnecessary duplication. The Departments intend to implement any transparency reporting requirements applicable to non-QHP issuers and non-grandfathered group health plans only after reasonable notice and comment, and after giving those issuers and plans sufficient time, following the publication of the final rules, to come into compliance with those requirements.

III. Submission and Display of Data

The transparency in coverage initial data collection will be through a separate reporting process other than the information required for certification, i.e., through an email address set up by CMS for this purpose. In the future, we intend to align the collection for FFM QHP issuers and issuers in SBM states that use the federal IT platform with the FFM QHP certification process through the Health Insurance Oversight System (HIOS) and the NAIC System for Electronic Rate and Form Filing (SERFF).

For initial implementation, each QHP issuer's information will display separately in a public use file (PUF) available on data.healthcare.gov. CMS will display information regarding QHPs, including SADPs, offered through HealthCare.gov in a more dynamic format in future years and will seek feedback on that display through a revision to this ICR.

Appendix A contains the data elements that CMS proposes issuers will submit and/or that CMS will display, for 2016 through 2018. As noted previously, CMS may propose additional data elements for 2018 collection and display at a later time. Specifically, CMS is considering whether to require issuers to submit information in the future regarding:

- The number of claims denials, based on CMS-designated reason codes;
- The number and percentage of mental health claims approved versus the number; and
- The percentage of medical/surgical (non-mental health) claims approved.

The data elements that CMS proposes to display are also below in Section IV: Data Elements for Display.

To the extent possible, CMS will reuse existing data that it and other entities collect through other means. CMS will also consider issuers' submission of required data to HHS as fulfillment of the requirement for issuers to submit information to the Marketplace and post on issuers' own websites, with the exception of the Claims Payment Policies and Procedures information as specified below. States may consider issuers' submission of data to HHS as fulfillment of the federal requirement to submit information to the state insurance commissioner.

IV. Data Elements for Collection and Display (See Appendix A - QHP Issuer Data Collection)

CMS seeks feedback on the information we will collect and display for 2016 through 2018, as noted in Appendix A.

- **Claims payment policies and practices.** QHP issuers will provide CMS one URL that will link to a landing page on issuers' websites. This URL will be optional in year 1 (2016) and required in years 2 and 3 (2017-2018). Consequently, CMS will post the URL for issuers that voluntarily submit one in year 1. This page will contain information on claims payment policies and practices. Note that CMS is not seeking to collect data points on the policies and practices.
    - Information provided on the QHP issuer's website should include issuer-level policies applicable to QHP enrollees on the following:
        - Out-of-network liability and balance billing (Issuers should provide information regarding whether an enrollee may have financial liability for out-of-network services; any exceptions to out-of-network liability, such as for emergency services; and whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.); and
        - Enrollee claims submission (Issuers should provide general information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim.).

    We anticipate that issuers may already have this material posted on their websites or in other documents. Issuers could link to existing documents that provide this information, such as plan documents or a completed summary of benefits and coverage (SBC) that complies with the requirements of 45 CFR 147.200 with respect to the coverage, if those documents provide the required information. Alternatively, issuers could fulfill this requirement by providing a few sentences or a short paragraph explaining each topic. For example, for "enrollee claim submission," an issuer might explain how an enrollee could submit a claim if the provider did not, including information regarding any required form to complete and a mailing address.

    Consumers and the general public must be able to easily access this information via the URL, such that people do not have to log on, create a user ID, or be enrolled in a

plan to view the information. CMS expects issuers to update the information within 7 business days of any change in policy described on the webpage. We believe that this level of information will be most useful to consumers. If policies are more granular than at the issuer level (e.g., if there are variances due to applicable state laws or based on small or large group market) issuers must present all applicable material in a clear manner. Issuers may include multiple links on the landing page. Such links should be in a self-explanatory and simple format. For example, the landing page could direct consumers to a link for each claims payment policy and practice item, and that link could contain state- and/or market-specific information.

- **Claims denials.** Starting in 2017, issuers will provide figures on denied claims for the preceding year, which CMS will display in a PUF. Issuers will also provide information on the number of internal and external appeals filed, and the disposition of the appeals.

- **Periodic financial disclosures**. Periodic financial disclosures from QHP issuers will not be a new data collection; however, it will be a new display in a PUF, starting in 2016. CMS will display prior calendar year issuer-level information about premiums, assets, and liabilities that the NAIC currently collects and displays, and which is currently publicly available.

- **Data on enrollment**. CMS will display issuer-level enrollment numbers as derived from HealthCare.gov starting in 2016; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year's information, and CMS will display this information in a PUF.

- **Data on disenrollment.** Starting in 2017, issuers will display issuer-level disenrollment numbers. CMS will display this information in a PUF.

- **Data on rating practices.** CMS will rely on the plan-level Unified Rate Review data that is currently collected annually and displayed on data.healthcare.gov. CMS already requires issuers to submit this information and would not require duplicate submission.

- **Information on cost-sharing and payments for out-of-network coverage.** HealthCare.gov currently links to an issuer's current year SBC. The SBC includes information on cost sharing, including cost sharing for out-of-network services. CMS does not propose new collection or display for this data element.

- **Information on enrollee rights under Title I of the Affordable Care Act.** CMS will provide a URL to the enrollee rights and protections information provided on HealthCare.gov, which is available at https://www.healthcare.gov/health-care-law-protections/. CMS does not propose a new collection effort for this data element.

- **Other information as determined appropriate by the Secretary.** Issuers will display additional information that will assist consumers in understanding their coverage. This will be optional for issuers in 2016 and required for 2017 and 2018. The same standards

explained under "claims payment policies and practices," above, would apply. That is, issuers would provide one URL that would link to information on claims payment policies and practices as well as the information described below, and may link to existing documents that provide this information, such as plan documents, if such documents exist. CMS will display the URL in year 1 (2016) for issuers that voluntarily submit one. Information provided on the QHP issuer's website should include issuer-level policies applicable to QHP enrollees on the following:

- Grace periods and claims pending policies during the grace period (Issuers would provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d), including that issuers must pay claims during the first month and may pend claims during the second and third months. Issuers could explain how they process claims during the 90 day grace period, what a pending claim is, and that enrollees could ultimately be financially responsible for claims payment.);
- Retroactive denials (Issuers would explain that claims may be denied retroactively, after the enrollee has obtained services from the provider.);
- Enrollee recoupment of overpayments (Issuers would provide written instructions to enrollees on obtaining a refund of overpayment for services.);
- Medical necessity and prior authorization timeframes and enrollee responsibilities (Issuers would provide an explanation that some services may require prior authorization. The guidance could also note, for example, any ramifications should the enrollee not follow proper prior authorization procedures, a time frame for the prior authorization, and that some coverage is subject to review for medical necessity.);
- Drug exceptions timeframes and enrollee responsibilities (The issuer would provide an explanation of the internal and external exceptions process for people to obtain non-formulary drugs, pursuant to 45 CFR 156.122. The explanation should explain the time frame for a decision, how to complete the application, and the review process.);
- Information on Explanations of Benefits (EOBs) (The issuer would provide an explanation of what an EOB is, when an issuer sends EOBs, and how a consumer should read and understand the EOB.);
- Coordination of benefits (COB) (The issuer would explain what COB is and that other benefits can be coordinated with the current plan to establish payment of services.); and;
- Issuer contact information so that CMS can follow up with the issuer in the event of any questions.

2. Information Uses

CMS expects consumers to access this information to make informed plan selections and understand their rights as consumers. This information will enable consumers to select a plan that best meets their needs.

Additional information phased-in over the next few years for QHP transparency reporting, which is not reflected in this ICR, could be used by researchers and stakeholders. Nothing would

prohibit researchers and stakeholders from using the information in this package. CMS does not intend to use the information submitted in this ICR for oversight purposes. However, CMS will consider using the information in future revisions to this ICR for oversight purposes.

3. Use of Information Technology

CMS anticipates that the availability of transparency in coverage information on-line will aid consumers in efficiently selecting a plan and using their benefits.

4. Duplication of Efforts

We anticipate no duplication of effort for issuers.

QHP issuers currently provide URLs for consumer SBCs and the Unified Rate Review Template for other purposes, and CMS intends to leverage this information to eliminate duplicate reporting. CMS also plans to link to financial information that issuers report to the NAIC rather than collecting new information.

5. Small Business

QHP issuers will incur costs to make this information available on their websites and to HHS. However, CMS does not have reason to believe that any issuers are small businesses. The data collection will benefit consumers, including small businesses that may wish to purchase coverage through the Small Business Health Options Programs (SHOP).

6. Less Frequent Collection

The burden associated with this information collection consists of QHP issuers updating specific data elements related to transparency in coverage. QHP issuers are required to make this information available to consumers and CMS. CMS will require QHP issuers to update transparency in coverage data annually. Less frequent collection would reduce the utility of the information and consumer benefit.

7. Special Circumstances

There are no anticipated special circumstances.

8. Federal Register/Outside Consultation

A Federal Register notice will be published, providing the public with a 30-day period to submit written comments on these ICRs.

CMS sought public comment on transparency reporting requirements in the rules *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Proposed Rule* (76 Federal Register 41866, July 15, 2011) and *Patient Protection and Affordable*

Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule (79 Federal Register 70674, November 26, 2014). CMS carefully reviewed all comments received and took those comments into consideration as part of the approach outlined in this supporting statement.

9. Payments/Gifts to Respondents

No payments and/or gifts will be provided.

10. Confidentiality

To the extent of the applicable law and HHS policies, we will maintain consumer privacy with respect to the information disclosed.

11. Sensitive Questions

No sensitive questions are included in these notice requirements.

12. Burden Estimates (Hours & Wages)

The following section of this document contains an estimate of the burden imposed by the associated ICRs. Salaries for the positions cited were completely taken from the Department of Labor Bureau of Labor Statistics (BLS) website (http://www.bls.gov/oes/). Based on comments received and changes to the proposed collection, CMS has increased the burden estimates.

CMS estimates that in the first year, it will take 42 hours per year for a QHP issuer to meet this reporting requirement, which will occur annually and consists of updates to claims and enrollment information to consumers, and to CMS in a template specified by HHS. We estimate that in subsequent years, it will take 30 hours per year. The increased burden in the first year accounts for initial set-up time.

CMS estimates 475 QHP issuers (individual, SHOP and stand-alone dental (SADP)) will offer QHPs in an FFM or SBM using the federal IT platform and thus be subject to this requirement during this initial implementation phase. The estimate of 475 is based on the number of issuers whose QHPs, including SADPs, appeared on HealthCare.gov in the 2015.

On average, in the first year, we estimate that it will take a health policy analyst 32 hours (at $58.05 an hour), an operations analyst4 hours (at $56.63 an hour), and a senior manager 6 hours (at $103.95 an hour) to fulfill these requirements. The total estimated burden is $2707.82 per year, per reporting entity for an aggregate burden of $1,286,214.50 for all issuers.

Table 1: Burden to QHP Issuers in Year 1

Labor Category	Number of Employees	Hourly Labor Costs (hourly rate + 35% fringe benefits	Burden Hours	Total Burden Costs	Total Burden Cost (per year)
Health Policy Analyst	1	$58.05	32	$1857.60	
Operations Analyst	1	$56.63	4	$226.52	
Senior Manager	1	$103.95	6	$623.70	
Total per Issuer			42	$2707.82	
Total for the 475 QHP Issuers					$1,286,214.50

In years two and three, we estimate that it will take a health policy analyst 25 hours per year (at $58.05 an hour) and a senior manager 5 hours (at $103.95 an hour) to fulfill these requirements. This is a total of $1971.00 per issuer per year for an aggregate burden of $936,225 for all 475 issuers. However, as noted previously, as we phase in additional reporting requirements and reporting by additional issuers beyond Year 1, we intend to revise the burden estimate and seek further comment through revisions to this ICR.

Table 2: Burden to QHP Issuers in Years 2 and 3

Labor Category	Number of Employees	Hourly Labor Costs (hourly rate + 35% fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Cost (per year)
Health Policy Analyst	1	$58.05	25	$1451.25	
Senior Manager	1	$103.95	5	$519.75	
Total per Issuer			30	$1971.00	
Total for the 475 QHP Issuers					$936,225

Office of Management and Budget (OMB) approvals are for three years. Therefore, the aggregate burden for years one through three across all 475 issuers is $3,158,664.50($1,286,214.50 in year one + $936,225 x 2 for years two and three).

13. Capital Costs

There are no additional capital costs.

14. Cost to Federal Government

There are no additional costs to the federal government.

15. Changes to Burden

This is a new information collection.

16. Publication/Tabulation Dates

The updating of transparency in coverage data occurs annually. The data collected will be submitted to CMS and made public on HealthCare.gov annually to ensure the most up-to-date information is available to Marketplace consumers.

17. Expiration Date

CMS has no objections to displaying the expiration date.