Transparency in Coverage Summary of 60-day Comments

Category	Comment Summary	Response
Timing	Clarify the timing of when the URLs go live for the general public.	We will provide further guidance and training on the process and timing once we finalize the package. We expect this to happen sometime in 2016.
	Accelerate the implementation process.	CMS seeks to balance the need to provide the public with accurate information and provide issuers with adequate time to collect and provide data. We do not believe it is possible to display the information any sooner. However, based on comments received, we are proposing to accelerate the phased-in approach by collecting and displaying additional information in year 2 (2017).
	Provide the final data elements and format at least six months in advance of the submission deadline.	CMS intends to provide sufficient time for issuer submission. CMS will also provide instructions and guidance on submitting the information. Because the proposed first year's data collection is limited, CMS does not believe that six months is required.
Scope of data collection	Reporting requirements should be consistent for all group plans including those sold on and off the Marketplaces, individual, small group, grandfathered, large group, and self-insured.	CMS plans to implement a phased in approach and will consult with the Departments of Labor and Treasury. In addition, HHS, the Department of Labor, and the Department of Treasury intend to propose transparency reporting rules for non-QHP issuers and non-grandfathered group health plans, and those rules may differ from the rules for QHP issuers and will take into account differences in markets, and other relevant factors.
	Collect of data such as race, ethnicity, gender, sexual orientation, age, health status, disability, geographic location, enrollee income, and primary language to support evidence-based policymaking that addresses health disparities.	These data elements might be valuable, particularly for researchers and to inform policymaking, and we may consider adding these data elements in a future PRA package. Issuers do not currently collect all of this information, however. We also have concerns about collecting information regarding some of these factors, as applicants and enrollees

		are not required to report all of this information. We will consider this suggestion for the second phase of implementation.
	Using EDGE server data for the ACA's risk-mitigation programs could be used for transparency purposes as well.	The EDGE server does not contain data that could be used for transparency purposes.
	Do not require submission/display of data elements for stand-alone dental plans (SADPs) that do not apply to dental.	Revised Appendix A specifies what applies to SADPs.
	Develop common definitions to ensure the data collected are accurately represented.	CMS will add common definitions to the data collection process.
	Implement controls to ensure the secure transfer of data from issuers to CMS.	Initially, issuers will send information to a secure email address. CMS has used this approach with other data collections. Ultimately, we intend to integrate data collection with qualified health plan (QHP) certification.
	Display plan level data.	Displaying data at the issuer level provides more comprehensive information that we believe is more meaningful to consumers. Displaying information at the plan level could result in displaying data anomalies due to low enrollment in a particular plan. We will consider whether to display certain elements at the plan level as part of phase II (likely 2019 and beyond).
Data display	Display data in user friendly format such as the Public Use Files (PUF), not a landscape format.	CMS intends to display the data using a public use file (PUF).
Oversight	Transparency data collected should be used for oversight and enforcement purposes.	As noted in the Supporting Statement, CMS does not intend to use the data for oversight purposes at

		this time. However, we may do so in the future, as part of phase II (likely 2019 and beyond).
	Provide information to State commissioners relevant to their state.	Information will be made available to States for public view.
Out-of-network coverage	Collect information on cost-sharing and payments with respect to any out-of-network coverage.	CMS is not collecting this information at this time, due to cost fluctuation for out-of-network services.
Data on claims denials	Do not display information on claims denials at this time.	In our phased in approach, we will initially collect claims denial and internal and external appeals figures. We consider this data collection element to be useful to consumers.
	Issuers should report paid and unpaid claims data by age and income, with diagnosis and service codes.	CMS will consider this approach or a similar approach for phase II. We note that requiring such reporting is likely to be labor-intensive and want to provide sufficient time for issuers to ensure their systems are capable of this type of reporting.
Claims payment	Post plan performance measures of claims payment timeliness	We will consider this for the future. We note that the MCAS requires similar reporting. We will wait for finalization of the MCAS before requiring this of issuers, so as not to duplicate efforts.
	Collection of website link for claims payments only is insufficient.	CMS is using a phased approach. We fully intend to collect additional data as part of phase II.
	Report additional claims data.	CMS will determine what additional data elements would be useful to consumers for phase II.
Pending claims/grace periods	Reporting should indicate if the pending claim is in the grace period.	We are not proposing to require issuers to report on specific claims that fall in the grace period; we are asking issuers to provide consumers information on grace periods and pending claims policies. We will consider this suggestion for phase II.

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Retroactive denials	Remove the retroactive denial category and add claims denials category only.	We think it is important for consumers to know claims can be denied retroactively, so that they are aware of the potential for further financial liability.
	Commenter supports our proposal not to collect claims denial information at this time.	We appreciate the comment and will move forward with a phased in approach.
Data on rating practices	No proprietary or confidential information should be released to the public.	We do not propose releasing any confidential or proprietary information.
	Data should not be made available until after the completion of the QHP certification process.	CMS intends to display the existing Unified Rate Review (URR) data.
	Utilize this information to indicate whether a plan's premium was determined unreasonable and to link to additional rate-review information.	CMS (and States) already use the information collected on the Unified Rate Review Template (URRT) to determine whether rates are unreasonable. CMS and States are already required to make rating information available to the public by providing a link to the rate filing justifications.
	Display data via the URRT.	We are not proposing to display separately. We currently display the data via the URRT.
Disenrollment data	Disenrollment data should be collected and posted in 2017.	This data element will be posted in 2017.
	Disenrollment data should be presented only after studies have been conducted assessing reviewer responses.	The proposal for collection and display of disenrollment data takes into account concerns raised during the 60-day comment period. For phase I, issuers will report overall disenrollment figures.
	Reports should reflect the age and significant medical diagnosis associated with each disenrollment.	As noted above, we intend to require issuers to provide reason codes for disenrollments as part of phase II. At that time, we will consider the feasibility of this suggestion. However, we think it is unlikely that there are medical diagnoses attributable to

		each disenrollment. For example, people may disenroll because they move to a different area or become eligible for other coverage.
	Modify to indicate whether the dis-enrolled individual was in a premium grace period immediately prior to disenrollment.	We will consider this for phase II.
Information on enrollee and participation rights	Analyze these data in light of ACA nondiscrimination standards.	States have primary responsibility for form review and for ensuring that issuers meet market wide standards, including non-discrimination standards. As part of QHP certification in the Federally-facilitated Marketplaces (FFMs), CMS currently reviews plans for discriminatory benefit design.
Drug exceptions timeframes and enrollment responsibilities	Do not include this information until there has been time to see how state insurance regulators decide to proceed with incorporating the drug exceptions process into the external appeals process, if at all.	The drug exceptions process is in our regulations, and issuers are expected to follow it. Issuer-provided information must be accurate.
Periodic financial disclosure	Provide information indicating whether each issuer displayed on the site owed medical-loss ratio rebates in the prior year.	Because this information is currently available on the CCIIO website: at https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html, we do not intend to duplicate this reporting requirement.