

Information Collection:
Transparency in Coverage Reporting by
Qualified Health Plan Issuers
(CMS-10572/OMB control number: 0938-1310)

A. Background

On March 23, 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law. 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 Exchanges, which give millions of Americans access to affordable, quality insurance options. By providing a place for one-stop shopping, Exchanges 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 Exchange, and the state insurance commissioner.

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

On June 16, 2016, the Office of Management and Budget (OMB) granted approval for the *Transparency in Coverage* Paperwork Reduction Act (PRA) package, for a 3-year collection period, expiring June 30, 2019 (OMB Control Number 0938-1310). This Information Collection Request (ICR) serves as a formal request for the renewal of the data collection. It also includes a request for revisions to the previously approved data collection. Based on the continued pursuit of transparency, revisions to this data collection will be applicable for 2019 data collection and beyond. Revisions will be incorporated with previously approved data elements.

B. Justification

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 tri-Department rulemaking.

1. Need and Legal Basis

I. Regulatory Background

Pursuant to 45 CFR 156.220, in order to increase transparency of QHPs in the individual and small group markets on the Exchange and Small Business Health Options (SHOP) Marketplace, including Stand-alone Dental Plans (SADPs), issuers must submit specific information about coverage to HHS, the Exchange, 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 and 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 the Federally-facilitated Exchanges (FFE) and State-based Exchanges on the Federal Platform (SBE-FPs) began in 2016 plan year. We intend to continue this collection through the 2021 plan year.

II. Future Tri-Department Transparency Reporting Rulemaking for Non-QHP Coverage

The current collection and proposed revised collection apply to issuers in FFEs and SBE-FPs. Consistent with the requirements of PHS Act section 2715A, HHS and the Departments of Labor and the Treasury (collectively, the Departments) intend to propose other transparency reporting requirements at a later time, through a separate rulemaking conducted by the Departments, for non-Exchange coverage, including 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, and will take into account differences in markets, reporting requirements already in existence for non-QHPs (including group health plans), and other relevant factors. The Departments also 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. At this time, we do not propose extending the collection to QHPs in State-based Exchanges, market-wide, or to plans regulated by the Department of Labor, as contemplated by statute. However, we propose to work with them to phase in those requirements with the next PRA package (in three years).

III. Submission and Display of Data

In previous collections, the transparency in coverage initial data collection was submitted 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. We will continue the collection through this process for at least the 2021 plan year.

QHP issuers' information will continue to be displayed separately in a landscape file available on data.healthcare.gov. CMS will display information regarding QHPs, including SADPs, offered through HealthCare.gov. Additionally, we are exploring displaying the data during the QHP selection process.

Appendix A contains the data elements that CMS proposes issuers submit or display. The data elements that CMS proposes to display are in Appendix B and below in Section IV: Data Elements for Display. Note that because CMS plans to rely on other data sources in addition to issuer-reported data, the data elements for display include some elements not noted in Appendix A. Appendix D contains detailed instructions for issuers regarding the data to submit.

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 Exchange 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 (See Appendix A - QHP Issuer Data Collection)

CMS seeks feedback on the information we will collect as noted in Appendix A. This includes issuer contact information and a URL that will link to issuers' websites.

V. Data Elements for Display (See Appendix B - QHP Issuer Data Display)

CMS seeks feedback on the information we will display, as noted in Appendix B and as follows:

- **Claims payment policies and practices.** QHP issuers would provide CMS one URL link titled "Transparency in Coverage" which will link to a landing page on the issuers' websites containing information on claims payment policies and practices. Note that CMS is not seeking to collect data points on the policies and practices. This will not be a new data collection.
 - 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

- o 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.).

Issuers could link to existing documents that provide this information, such as plan documents, if such documents exist, or a completed summary of benefits and coverage (SBC) that complies with the requirements of 45 CFR 147.200 with respect to the coverage (including contact information that is required to be provided). 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. **More detailed instructions on what issuers should submit are in the instructions in Appendix D.**

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.

- **Periodic financial disclosures.** 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 the issuer-level enrollment numbers as derived from HealthCare.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Data on disenrollment.** CMS will display the issuer-level disenrollment numbers as derived from Health.Care.gov; therefore, this will not be a new data collection. This number will be based on the end of the prior calendar year’s information.
- **Claims Data.** Issuers will provide issuer-level data based on the following categories: claims received; claims denied; internal appeals filed; internal appeals overturned; percent of internal appeals overturned; external appeals filed; external appeals overturned; and percent of external appeals. This is not a new collection.

- **Plan level claims denial.** Issuers will categorize all claims denials into one of several denial code categories, leveraging the NAIC Market Conduct Annual Survey (MCAS) work. Issuers would report the number of claims in each category. This approach aligns with NAIC denial classification and provides greater transparency as to why issuers deny claims, which may be useful to consumers and stakeholders. Issuers will provide the number total number of plan level claims and the number of plan level claims denials based on the following denial categories: 1) Referral or prior authorization required: Issuers would report denials of non-emergency-related claims that may require prior authorization, or a referral, 2) Out of network provider/claims: Issuers would report denial of claims for services from outside of the plan’s network of healthcare providers when the plan has a closed network, 3) Services excluded or not covered: Issuers would report denial of claims for services exclusion or non-covered services that are not covered benefits, 4) Not medically necessary, excluding behavioral health: Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnose or treat of an illness, injury, condition, disease, or its symptoms related to medical surgical services, 5) Not medically necessary, including behavioral health: Issuers would report claims denied for health care services or supplies that do not meet the accepted standards to diagnosis or treat of an illness, injury, condition disease, or its symptoms, related to behavioral health, and 6) Other: issuers would report claims rejected for a variety of reasons including incorrect coding, patient not insured by the plan, duplicate claims, coordination of benefits issues, untimely claims filings. This proposes to expand on the current collection.
- **Data on rating practices.** CMS will rely on the plan-level Unified Rate Review data that is 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. 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. 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 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 PRA package for oversight purposes. However, CMS will consider using the information in future revisions to this PRA package 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 Summaries of Benefits and Coverage (SBC) 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 Notice was published in the federal register on October 23, 2018, (<https://www.federalregister.gov/documents/2018/10/23/2018-23027/agency-information-collection-activities-proposed-collection-comment-request>) providing the public with a 60-day period to submit written comments on these information collection requirements (ICRs). We received one comment during that time.

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 privacy with respect to the information provided.

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 information collection requirements (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/>).

CMS estimates that 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.

CMS estimates 470 QHP issuers (individual, SHOP and stand-alone dental) will offer QHPs in an FFE or SBE-FP and thus be subject to this requirement during this initial implementation phase. The estimate of 470 is based on the number of issuers whose QHPs, including SADPs, appeared on HealthCare.gov in the 2019 plan year.

On average, in the first year, we estimate that it will take a Social Science Research Assistant 32 hours (at \$31.18 an hour), an Operations Research Analyst 4 hours (at \$56.14 an hour), and a Senior Manager 6 hours (at \$101.34 an hour) to fulfill these requirements. The total estimated burden is \$1,851 per year, per reporting entity for an aggregate burden of \$869,744 for all issuers. Therefore, the aggregate burden for years one through three across all 470 issuers is \$869,744.

Table 1: Burden to QHP Issuers in Year 1-3²

² In the original package for this data collection, as approved June 16, 2016, for years one estimated a total of 475 issuers and a total of 34 hours, for a total burden of \$2154.46 per issuer.

Labor Category	Number of Employees	Hourly Labor Costs (hourly rate + 35% fringe benefits)	Burden Hours	Total Burden Costs	Total Burden Cost (per year)
Social Science Research Assistant	1	\$31.81	32	\$1017.92	
Operations Research Analyst	1	\$56.14	4	\$224.56	
Senior Manager	1	\$101.34	6	\$608.04	
Total per Issuer			42	\$1850.52	
Total for the 470 QHP Issuers					\$869,744.40

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

As a result of a decrease number of QHP issuers, there is a slight decrease in the number of QHP issuers considered in the total calculation, from 475 to 470 issuers, as a result of more reliable data. Furthermore, in the initial collection issuers needed to establish a new data collection process for year 1 with a burden estimate of 42 hours, then 30 hours for years 2 and 3. The burden hours have been adjusted accordingly from 72 hours to 42 hours.

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

The expiration date and OMB control number will be displayed on the first page (top right corner) of each instrument.