

Comment on CMS-2025-0041: Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS-10572)

Submitted via Regulations.gov

To Whom It May Concern,

Thank you for the opportunity to provide public comment on the proposed extension of the “Transparency in Coverage Reporting by Qualified Health Plan Issuers” (CMS-10572). I submit this feedback as a Master of Public Health candidate at the George Washington University—Milken Institute School of Public Health, with a background in strategic planning and public service. This proposed collection represents an important continuation of federal efforts to improve consumer protections and ensure accountability in the health insurance marketplace.

Support for Transparency in Coverage Reporting

Transparency is not an abstract ideal—it is a prerequisite for a functioning health insurance system. Sections 1311(e)(3)(A)-(C) of the Affordable Care Act (ACA), implemented via 45 CFR 155.1040 and 156.220, rightfully place obligations on Qualified Health Plan (QHP) issuers to disclose clear, plain-language information about coverage, cost-sharing, out-of-network policies, and claim denials. CMS-10572 supports this mandate by operationalizing a framework for information collection and public reporting that enhances regulatory oversight and consumer empowerment.

I fully support the continued implementation and extension of CMS-10572. Without structured, recurring data collection from QHPs, transparency requirements risk becoming performative rather than transformative. The information collected under this framework is essential to understanding how coverage is marketed, administered, and accessed—particularly for marginalized populations who face persistent barriers in the health insurance system.

Strengthening Utility and Usability

While the value of CMS-10572 is clear, I recommend several enhancements to maximize its impact for consumers, regulators, and researchers:

1. Improve Consumer-Facing Accessibility

CMS should consider redesigning the publicly accessible transparency tools to be mobile-responsive, multilingual, and visually intuitive. The current presentation of coverage data often overwhelms the average consumer, particularly those with limited health literacy. CMS could work with behavioral science experts to develop plan comparison tools that use icons, alerts, or simplified visuals to flag significant cost-sharing differences or limited networks.

2. Mandate Standardized Cost Reporting Formats

Variability in how issuers report estimated out-of-pocket costs for common services undermines the comparability of QHPs. CMS should enforce stricter formatting standards that allow consumers to easily contrast services such as specialty drug pricing, mental health visits, and emergency services across plans. A “top 25 services” reporting requirement could standardize high-impact comparisons.

3. Integrate Disparity Indicators

QHP transparency data could be a powerful tool for assessing equity—if CMS required issuers to report disaggregated utilization or denial rates by demographic subgroup (e.g., race, language, ZIP code). This would allow CMS and states to evaluate whether certain populations are disproportionately denied claims or face higher cost-sharing burdens for the same services.

4. Leverage Automation and Machine Learning

To reduce issuer reporting burdens while increasing data utility, CMS should explore partnerships with health tech firms and academic institutions to automate data parsing, detect anomalies, and identify emergent coverage trends. Machine-readable formats (JSON, XML) should be mandatory to enable third-party analysis and public accountability.

5. Publish an Annual Transparency Scorecard

To incentivize issuer compliance and foster competition on the basis of transparency and equity, CMS should consider publishing an annual summary report that includes a “Transparency Score” based on completeness, accessibility, and usability of issuer data. Publicizing this metric could drive insurer improvements without necessitating new penalties.

Equity and Public Trust

Transparency is especially critical as CMS continues to advance the equity agenda outlined in Executive Order 13985. Insurance opacity disproportionately harms communities with less access to brokers, digital literacy, or legal assistance. If properly structured, CMS-10572 can serve as an equity lever—democratizing access to information and leveling the playing field for historically underserved populations.

Furthermore, public trust in the healthcare system depends on the perception of fairness, consistency, and honesty in how coverage decisions are made and explained. Transparent data collection and dissemination are foundational to achieving this trust.

Conclusion

I commend CMS for its continued commitment to transparency and urge the agency to not only extend CMS-10572 but to expand its ambition. Health coverage in the United States remains opaque, confusing, and unevenly understood by consumers. With the right enhancements, this data collection can become a powerful force for consumer protection, equity, and system-wide accountability.

Respectfully submitted,

Michael Martin

Graduate Student, MPH Candidate

George Washington University – Milken Institute School of Public Health

June 20, 2025

Peter Nelson
Deputy Administrator and Director
Centers for Consumer Information and Insurance and Oversight (CCIIO)
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Submitted electronically via www.regulations.gov

RE: Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS-10572) – AHIP Comments

Dear Director Nelson:

AHIP appreciates the opportunity to submit comments in response to the Centers for Medicare and Medicaid Services (CMS) Information Collection Request on Transparency in Coverage Reporting by Qualified Health Plan (QHP) Issuers, published in a Paperwork Reduction Act (PRA) package (CMS-10572) on April 21, 2025. AHIP is the national trade association representing the health insurance industry. Our members provide health care coverage, services, and solutions to more than 200 million Americans, including millions who enroll in coverage through the individual market through the Health Insurance Marketplaces. AHIP and our member health plans are committed to ensuring Americans who buy their own health insurance coverage continue to have access to quality, affordable coverage that meets patients' needs and advances their health and wellbeing.

We share the Administration's goal of ensuring consumers have access to actionable information about their health coverage. The Affordable Care Act (ACA) requires QHP issuers to publish data related to Transparency in Coverage requirements—including enrollment trends, out-of-network coverage, and claims payments and denials—in clear, plain language. Because this data is publicly available, it is critical that CMS ensures the collection of high-quality data that yields accurate, meaningful insights for consumers.

Health plans approve the overwhelming majority of claims they receive and are committed to helping their members access timely, effective, and affordable care. Preliminary results of an ongoing AHIP study found that denials often result from administrative issues such as duplicate claims, services not covered under a member's benefits, and incomplete or incorrect provider submissions. In many cases, these denials stem from procedural errors rather than actual coverage decisions. However, the current reporting process often misrepresents both the volume and the nature of claims denials. AHIP's preliminary results suggests an ultimate claim denial rate of less than 3.5%. We will share more information on the final results in the near future.

Transparency in Coverage reporting should provide meaningful information to consumers while reducing regulatory burden. The Administration has emphasized the importance of deregulation and removing requirements that are "unduly burdensome."¹ We support efforts to improve the regulatory process and believe enhancing the accuracy and utility of Transparency in Coverage data while simplifying the reporting process will more provide more meaningful transparency to consumers while reducing regulatory burdens. Streamlining the reporting requirements would better meet the objectives of President Trump's Executive Order 14192 by reducing administrative burden and complexity. We offer the following recommendations to streamline how issuers and CMS identify and report on denials, as well as to improve the provider claims submission process to reduce denials overall.

- **Collect and publicly report claims denial information based on final determination.**
When a claim must be modified or resubmitted, issuers may either pend or deny a claim, and the provider will then either modify the pended claim or resubmit the denied claim. Whether the claim is pended or denied typically depends on legal requirements, including claims processing requirements under the No Surprises Act or ERISA. Although the outcome is the same, the current reporting process may show different denial reasons based on the path taken—creating inconsistent and misleading data. This is especially problematic for issuers that deny that need to be resubmitted. Allowing issuers to categorize denials based on the final determination or reason for denial, and not the intermediate steps taken to process the claim, will provide a better picture of the substantive reasons for denials and filter out denials that were eventually addressed by providers.
- **Improve the claims denials reporting process to better distinguish between substantive denials and technical denials, or administrative errors, by removing the**

¹ <https://www.govinfo.gov/content/pkg/FR-2025-04-11/pdf/2025-06316.pdf>

“Administrative” category. The current process requires issuers to categorize claims denials by reason, including a broad “Administrative” category. Many of the claims included in this category are due to provider errors or other procedural issues, such as duplicate submissions or incorrect information, and are substantively different from actual denials. However, this distinction is not made clear in public reporting and therefore inflates denial figures and may confuse or alarm consumers. For example, a provider submits three claims for the same service. One claim is paid, but the other two are denied because they are duplicative. Although the issuer fully paid for the services their enrollee received, reporting will show that the issuer denied two of the three submitted claims. This reporting would be misleading and confusing, as it does not represent the public concept of a claim denial.

In addition, the “Administrative” denials category often overlaps with the “Other” category, making it unclear as to which category an issuer should select based on the denial reason. This only confuses the data further and obscures reporting. To ensure Transparency in Coverage data does not conflate “substantive denials” with “technical denials,” or administrative reasons, we recommend CMS eliminate the “Administrative” category and require that all claim denials attributable to administrative errors be reported under the “Other” category. This would streamline the reporting process and reduce confusion.

- **Do not finalize the proposed Behavioral Health and Pre-Service Claims data requirements.** CMS proposes to revise data submission to separately report data related to behavioral health claims versus non-behavioral health claims. This proposed change would significantly increase administrative burdens for health plans without corresponding added value for consumers. Finalizing this requirement would create unnecessary complexity and cost for QHP transparency reporting
- **Enhance data accuracy by removing the “Investigational, cosmetic, or experimental procedures” category.** The “Investigational, cosmetic, or experimental procedures” category overlaps with other claims denials categories and obscures the fundamental, necessary purpose of claims review. For example, if an issuer covers all cosmetic procedures but excludes procedures that are not medically necessary, then that claim should be reported as a denial due to “Medical necessity,” and not due to “Investigational, cosmetic, or experimental procedures.” This category does not provide meaningful data to consumers, as it can lead to variations in how issuers categorize and report claims data and further confuse “substantive” and “technical” denials. To enhance data accuracy, simplify the reporting process, and reduce consumer confusion, we recommend CMS remove the “Investigational,

cosmetic, or experimental procedures” category and clarify whether issuers should map related claims denials to the “Medical necessity” or “Exclusion of service” category.

- **Exclude reporting of duplicative and zero-dollar pharmacy claims data.** Pharmacists often submit multiple pseudo-claims for a medication to test benefit coverage or gather additional information. This may include submitting different timeframe versions of a claim (30-day vs. 90-day supply) to check which formulation is covered or submitting different types of prescriptions (generic vs. brand name) to see how they affect a member’s out-of-pocket cost. These “test” claims often do not represent the actual prescribing of medication and are intended to help consumers and pharmacies obtain additional information about certain prescriptions. In addition, pharmacists may submit a claim and reverse it shortly thereafter (if a patient does not pick up the medication, for example), leaving a zero-dollar claim in the data. These duplicative and zero-dollar claims undermine Transparency in Coverage reporting by inflating denials volumes. In fact, the NAIC Market Conduct Annual Survey (MCAS) excludes duplicative and zero-dollar pharmacy claims denials from its reporting for these reasons, among others. Similar to our recommendation regarding technical denials, we recommend CMS exclude reporting of duplicative and zero-dollar pharmacy claims data to improve the accuracy of denial reporting and reduce consumer confusion.
- **Include an indicator if public data sets are under review or appeal to increase transparency and public trust.** There have been instances in which CMS has published QHP Transparency in Coverage data on claims denials and appeals that included errors and must work with issuers to resolve data errors. To improve data transparency and public confidence in reported information, we recommend CMS add a visible flag or notation to identify any QHP Transparency in Coverage data set that is under review or appeal or being updated. This will inform stakeholders of any discrepancies or questions regarding the dataset’s accuracy and prevent misinterpretation during the review period.
- **Shift from plan-level to product-level data reporting.** Currently, issuers submit claims denials data as part of the QHP certification process. Claims denial data is reported at the plan level, but networks, claims adjudication logic, medical necessity guidelines, and covered benefits exist at the product level.² Shifting to product-level reporting would enhance data

² A product comprises all plans with the same cost-sharing, provider network, and combined service areas. See 45 CFR 144.103 for the definition of “[Plan](#)” and “[Product](#)”.

accuracy by promoting consistency across QHP reporting requirements and increasing the quantity and quality of the data. Issuers do not have precise plan-level data for plans that are terminated between the reporting year and the year used to collect data. For example, this year, issuers will report plan year 2024 denial rates as part of the plan year 2026 certification process. If a plan is discontinued in 2025 and enrollees are cross-walked to a new plan for 2026, the current process captures denial data only at the issuer level, losing visibility into plan-specific trends. Product-level reporting would improve the quality of the sample and reduce the risk that any potential inaccuracies. As such, we recommend CMS require data submission at the product level to better align with certification processes and improve the accuracy of reported data, particularly for products with discontinued plans.

- **Define “out-of-network” (OON).** CMS should clarify that an OON denial refers to a claim that was denied because the provider does not participate in the plan network, and not because the enrollee pays the cost sharing for an OON service.
- **Facilitate more streamlined mapping QHP Transparency in Coverage denial categories.** To standardize and streamline the reporting process, we recommend CMS instructions match X12 codes to a single denial category. Most issuers use proprietary codes internally but are able to map to X12 codes. This illustration would help issuers create uniform mapping between their internal denial codes and the Transparency in Coverage denial categories.
- **Revert the Transparency in Coverage Reporting deadline to late August or early September.** The Biden Administration moved the Transparency in Coverage Reporting deadline from late August or early September to mid-June to align with the QHP application deadline. However, June is an extremely demanding time for issuers, who are already managing QHP application submissions, rate filings, and other regulatory deadlines. To alleviate administrative burden, we recommend that CMS revert the Transparency in Coverage reporting deadline to its original timeframe.
- **Reduce misrepresentation of issuer data and consumer misinformation by strengthening disclaimer language.** The current disclaimer for QHP transparency public use files (PUFs) should be made more prominent and clarify that the data reflects only a subset of an issuer’s individual market enrollment and is not representative of other lines of business, including employer-provided coverage, Medicare Advantage, and Medicaid managed care. Given the current placement of disclaimer language on a separate tab, users may not review the disclaimer and may not be aware of the limitations or caveats of this data

and draw misleading conclusions from it. Disclaimers should be included in a more prominent location on each tab.

These improvements to the reporting process will increase transparency, enhance data quality, and empower consumers to make better informed decisions about their health care. AHIP looks forward to continued collaboration with CMS to support meaningful transparency and improve access to affordable, high-quality health care for all Americans.

Sincerely,

A handwritten signature in blue ink, appearing to read "Adam Beck". The signature is fluid and cursive, with the first name "Adam" and last name "Beck" clearly distinguishable.

Adam Beck
Senior Vice President
Commercial, Employer & Product Policy

PUBLIC SUBMISSION

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

Document: CMS-2025-0041-DRAFT-0004

Comment on CMS-2025-0041-0001

Submitter Information

Name: Anonymous Anonymous

General Comment

On Creditable Coverage Disclosure (CMS-10198)

Comment: Annual disclosure requirements can disproportionately burden small employers, unions, and community health plans with limited administrative staff. What steps will CMS take to reduce unnecessary paperwork or offer no-cost technical assistance for such entities?

Supporting Evidence: Small businesses cite administrative complexity as a barrier to offering health benefits (Kaiser Family Foundation, 2023; <https://www.kff.org/report-section/ehbs-2023-summary-of-findings/>).

On Essential Community Provider (ECP) Data Collection (CMS-10561)

Question: How will CMS ensure ECP data collection accurately reflects the presence of providers serving low-income and rural working-class communities, many of whom may lack staff capacity for complex reporting?

Supporting Evidence: Safety-net providers are often under-resourced, and administrative requirements risk limiting ECP participation (George Washington University Health Policy Institute, 2021; <https://publichealth.gwu.edu/projects/rwjf>).

Comment: Will CMS publish public-facing dashboards mapping ECP participation and network adequacy, empowering workers and unions to assess access gaps?

Supporting Evidence: Public health mapping tools have improved equity monitoring in Medicaid and ACA networks (Health Affairs, 2020; <https://www.healthaffairs.org/doi/10.1377/forefront.20201006.75238>).

On Transparency in Coverage Reporting (CMS-10572)

Question: Given persistent opacity in insurance billing and coverage decisions, how will CMS enforce plain-language transparency, particularly for non-English-speaking workers and those with limited digital access?

Supporting Evidence: Health literacy barriers undermine the effectiveness of transparency requirements for working-class populations (JAMA Network, 2022; <https://jamanetwork.com/journals/jama/fullarticle/2789499>).

Comment: Consider partnerships with labor unions and worker centers to disseminate coverage information and support workers in understanding their rights.

Supporting Evidence: Union health funds have demonstrated success in educating members on plan terms (International Foundation of Employee Benefit Plans, 2020; <https://www.ifebp.org/resources/research/benefit-surveys/Pages/default.aspx>).

On Genetic Information Nondiscrimination Act (GINA) Exception Notice (CMS-10286)

Question: What safeguards are in place to prevent the misuse of genetic data by employers or insurers, and how are workers educated about their rights and recourse under GINA?

Supporting Evidence: Evidence shows ongoing confusion and underreporting of GINA violations, especially among lower-wage workers (U.S. EEOC, 2023; <https://www.eeoc.gov/statistics/genetic-information-discrimination>).

On Student Health Insurance Coverage (CMS-10377)

Comment: Many working-class students rely on campus health insurance as their only coverage. What mechanisms will CMS use to ensure disclosures about actuarial value and plan limitations are clear and actionable for students balancing work and education?

Supporting Evidence: Student debt and underinsurance disproportionately affect first-generation and low-income students (Brookings, 2023; <https://www.brookings.edu/articles/the-student-insurance-gap/>).

On Medicare Participating Physician/Supplier Agreement (CMS-460)

Question: For smaller, rural, or minority-serving providers, do the current reporting and participation requirements present any disproportionate administrative or financial challenges, and is CMS evaluating possible simplifications?

Supporting Evidence: Rural and safety-net providers face greater administrative strain complying with Medicare rules (National Rural Health Association, 2024; https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/2024-NRHA-Rural-Health-Policy-Paper.pdf).

On Overall Burden and Technology

Comment: Will CMS provide grants or subsidies to smaller organizations and unions to help cover IT upgrades or staff training required for new or updated collection processes?

Supporting Evidence: Federal support for EHR adoption accelerated compliance in resource-limited settings (Health IT.gov, 2023; <https://www.healthit.gov/topic/meaningful-use-and-macra/what-meaningful-use>).

Question: Has CMS conducted an equity impact assessment to determine whether any of these information collections may unintentionally increase barriers to care or benefits for working-class people, including those with limited English proficiency or digital literacy?

Supporting Evidence: Federal equity assessments are increasingly standard in major regulatory changes (OMB, 2023; <https://www.whitehouse.gov/omb/briefing-room/2023/04/06/omb-issues-guidance-for-implementing-equity-action-plans/>).